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TRANSACTIONS

OF THE

TWENTY-SIXTH SESSION

OF THE

HOMŒOPATHIC MEDICAL SOCIETY

OF THE

STATE OF PENNSYLVANIA.

HELD AT PHILADELPHIA, SEPTEMBER 17-19, 1890.

PHILADELPHIA:
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SEVENTH AND CHERRY STREETS.
1891.

To the Homœopathic Medical Society of the State of Pennsylvania:

The Proceedings and Papers of the Twenty-sixth Session of the Society are hereby respectfully submitted.

Edward R. Snader, M.D.,
J. F. Cooper, M.D.,
J. Richey Horner, M.D.,
Committee on Publication.

JUL 26 1929

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OFFICERS.

1890.

President,	C. F. Bingaman, M.D.,	Pittsburgh.
First Vice-President,	C. S. Middleton, M.D.,	Philadelphia.
Second Vice-President.	C. H. Lee, M.D.,	New Castle.
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Recording Secretary,	J. Richey Horner, M.D.,	Allegheny.
Corresponding Secretary,	Edward R. Snader, M.D.,	Philadelphia.
Necrologist,	W. J. Martin, M.D.,	Pittsburgh.
Censors,	Joseph E. Jones, M.D.,	West Chester.
	Millie J. Chapman, M.D.,	Pittsburgh.
	Clarence Bartlett, M.D.,	Philadelphia.

1891.

President,	Augustus Korndœrfer, M.D.,	Philadelphia.
First Vice-President,	E. C. Parsons, M.D.,	Meadville.
Second Vice-President,	Millie J. Chapman, M.D.,	Pittsburgh.
Treasurer,	J. F. Cooper, M.D.,	Allegheny.
Recording Secretary,	J. Richey Horner, M.D.,	Allegheny.
Corresponding Secretary,	Edward R. Snader, M.D.,	Philadelphia.
Necrologist,	W. J. Martin, M.D.,	Pittsburgh.
Censors,	Sarah J. Coe, M.D.,	Wilkesbarre.
	Joseph E. Jones, M.D.,	West Chester.
	Clarence Bartlett, M.D.,	Philadelphia.

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PROCEEDINGS

OF THE

TWENTY-SIXTH ANNUAL SESSION

OF THE

HOMŒOPATHIC MEDICAL SOCIETY

OF THE

STATE OF PENNSYLVANIA.

PHILADELPHIA, PA., September 17th, 18th and 19th, 1890.

THE Twenty-sixth Annual Session of the Homœopathic Medical Society of the State of Pennsylvania convened in the Hahnemann Medical College of Philadelphia, on Wednesday, September 17, 1890.

The meeting was called to order by the President, C. F. Bingaman, M.D., of Pittsburgh.

Aug. Korndœrfer, M.D., President of the Philadelphia County Homœopathic Medical Society delivered an address of welcome.

MR. PRESIDENT, LADIES AND GENTLEMEN:

The Philadelphia County Society desires, through me, to extend to you, members of the Homœopathic Medical Society of the State of Pennsylvania, and visiting friends, each and all, a most hearty welcome to our city, our college, and our homes.

Guests as we have frequently been of our brethren in other cities, within the borders of this Commonwealth, we well remember the cordial good will with which we have been greeted and entertained. We trust, therefore, that you all will feel that we, too, find our greatest pleasure in your presence with us, at this our annual meeting.

We welcome you to our city, the home of Hering, Jeanes, Guernsey, Williamson, and other illustrious pioneers of Homœopathy, who though dead yet speak in works eloquent beyond words—works ever to be held in grateful remembrance by every member of our school.

When we cast a retrospective glance through the long vista of years past, contemplating the changes wrought since the days of Ihm and Bute, who singlehanded, amidst opposition, abuse, and ridicule, firmly established the true system of cure in our community, we feel that we may, in justifiable pride, stand here to-day to welcome you, worthy representatives of those principles for which they strove and for which they gained such victory.

May the spirit which inspired them perpetuate its work in and through us, until the great truth compassed by the law of similars shall have been developed in all its fulness, and all the nations of the earth share its blessings.

Again, I bid you WELCOME.

The President, Dr. Bingaman, made a suitable acknowledgment to the address of welcome, after which he relinquished the chair to C. S. Middleton, M.D., First Vice-President, and delivered the

PRESIDENT'S ANNUAL ADDRESS.

FELLOW-MEMBERS OF THE HOMŒOPATHIC MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA:

At the end of another year we meet to hold the Twenty-sixth Session of this Society. One year ago, our President turned back the pages of a quarter of a century, and showed what progress had been made in these years. At no time since medicine became a science, has it and its collateral branches made such advances. Homœopathy has kept pace—not falling back, as some would have you believe.

We now enter the second quarter of a century in the life of this society, with the names of twelve of its original members: Drs. J. C. Burgher, J. F. Cooper, John J. Detwiller, Owen B. Gause, H. H. Hofmann, Bushrod W. James, P. Liscomb, W. H. H. Neville, Mahlon Preston, Charles G. Raue, L. H. Willard, and Thomas C. Williams.

Would it not be well to make these members who have borne the burdens of this Society, Seniors, and they act as an advisory board?

We also have two hundred and seventy-six new members on our list, with hospitals and dispensaries to aid us in bringing about a still greater change. During the past year we see this magnificent hospital added to our Alma Mater; a new hospital in Reading, and we in Pittsburgh (thanks to a benefactress) are to have a Nurses' Home in conjunction with our hospital and training school.

Since our meeting in September last, we have lost four members by death: Dr. John Malin, of Germantown, who was Second Vice-President of this Society at the time of his death, November 19, 1889; Dr. W. B. Trites, died January 19, when his term of office as President of this Society had scarcely closed. Our Necrologist will pardon me if I say one passing word of this esteemed and much-loved man. I was shocked, as many others were, on learning of his death. In the prime of life, when prospects for the future were brightest, he was cut down. His labors ended when there seemed so much for him to do. May the example he has shown us in his upright, manly, Christian character, aid us in so living that when we are gone it may be said of us: *He was a good man.*

Dr. L. B. Hawley, of Phœnixville, answered death's summons on March 20th; and Dr. Thomas Nichol, of Montreal, Canada, on June 10th. Dr. Nichol was a corresponding member, and much respected by our members and the profession generally.

Probably, the most important question which should engage the attention of this Society is that of the "Medical Examiners' Bill" which our old-school friends would enact. I do not mean that all of the members of that school are in favor of legislation on this point. I have talked with quite a number of the most prominent at our end of the State, and find they are opposed to it. One said the appointments would be political, and representative men could not serve on such a board. As a rule, college professors are opposed, and feel it is an insult to take from them a duty or privilege and give it to a body of men less qualified to give judgment. The President of the Pennsylvania State Medical Association, in his address in June last, when referring to medical legislation, said it was a failure, and recommended "the abrogation of restrictive laws. The sooner the medical profession is rid of the legislative ideas the better."

The discussions were by no means harmonious before this body.

Some wanted to publish the names of the legislators who had voted against the passage of their last bill; others wanted to table everything relating to this subject.

The American Institute, at its last session, stood by its resolution of 1888, after a prolonged discussion, and I think this the proper attitude to take: Oppose medical legislation as far as possible, and when it becomes necessary demand our rights. This is the ground we are now on; for it is very evident we are to have a bill of some sort presented at the next session of our Legislature, judging from the action of the Pennsylvania Medical Association at its last meeting, held in Pittsburgh, in June last. A committee, composed of the presidents of each county society in the State, was appointed to prepare a bill to govern medical practice, said bill to be presented at the next session of the Legislature.

I see this committee has had a conference at Bedford Springs, looking towards the carrying out of the work assigned them. We must be ready to checkmate any unfair measures which may be proposed. There are those in the old-school ranks who would enact laws to cripple us, and, if possible, say to the people of this great State who they shall have to attend them when sick. They would strike at the very principles underlying our government. During the past year bills have been passed in several of the States, some for mixed, and, in New York, for separate boards.

Our colleges are gradually raising the standard of medical education. The American Institute, at its last session, upon the suggestion of its Collegiate Committee, voted to require a four years' course of medical study from all students entering colleges after the session of 1891–92. This is a very important step, and will be of vastly greater benefit to the public than any so-called Medical Examiners' bill. The course of study has been changed in England from four to five years.

I hope the Special Committee has given this very important subject due consideration. I would suggest that, after hearing the report, the Society defer action until the members have had time to reflect upon it.

My two predecessors have called your attention to a matter which I also wish to bring to your notice: The care of the insane of this Commonwealth. I do not want you to forget them. We had in

the various State and private asylums, including almshouses, during the past year 8382 insane persons, distributed as follows:

State Hospital for the Insane, Norristown,	2143
" " " " Harrisburg,	875
" " " " Dixmont,	906
" " " " Warren,	910
" " " " Danville,	1053
Pennsylvania Hospital for the Insane, Philadelphia,	571
Friends' " " " Frankford,	158
Philadelphia Almshouse, Insane Department,	1066
Private Asylum for the Insane, Burn Braæ,	46
Almhouses and Prisons,	654
	8382

Will simply give the percentage of recoveries and deaths during the past year, which show, when compared with the statistics Dr. Pitcairn so carefully prepared, that there is no improvement in the general results:

	Deaths.	Recoveries.
Asylum at Norristown,	6.48	4.24
" " Harrisburg,	6.74	4.00
" " Dixmont,	6.51	9.05
" " Warren,	7.03	4.83
" " Danville,	5.40	3.79

As the hospital years do not all commence at the same time it is very difficult to prepare accurate tables. The above figures are very nearly correct, however.

	Deaths.	Recoveries.
Middletown Insane Asylum, New York,	2.11	14.24
Westborough " " Massachusetts,	6.94	10 42

Both of these hospitals are under Homœopathic treatment. Westborough discharged eighty-one patients much improved, a percentage of 10.09. If those dying from acute diseases were not counted the death rate would be cut down almost two per cent.

So far as I can learn there is not one patient in any institution within our State under Homœopathic treatment. From what I can gather the Allopathic treatment for the insane amounts to almost nothing.

I quote from one report: "The year has added but little to our stock of knowledge or material. No new estimates made of such as were already in use, unless it be respecting sulfonal."

All of our asylums are full, and there is a pressing need for larger facilities for caring for these unfortunate persons. During the past year Dixmont added a new building, which was filled from the over-crowded condition of the main building.

I am not prepared to say whether the percentage of insanity is on the increase or not. The busy practictioner can probably form an idea when he stops to reflect and look over his case-book at the number who are bordering on this state still struggling to keep up with the bustle of everyday life. The early removal from the exciting cause I regard of the utmost importance. Where can we send our patients?

The above figures show what Homœopathic treatment can do. Why should we not have a State asylum under Homœopathic care? Almost half a million dollars were given to the various State asylums by the Legislature in 1888.

I would recommend that our Legislative Committee prepare a bill and present it at the coming session of the Legislature, asking that the new institution, which must be built, be placed in our hands.

There is one other subject I wish to bring to your attention, and that is the condition of our treasury. For years our esteemed treasurer has been carrying the burdens of this Society. He considers it of the utmost importance to have our Transactions out promptly, and to gain this end pays all bills whether he has Society funds or not. I understand at one time during the past year he had advanced about nine hundred dollars to meet the demands on our treasury. You will agree with me that this is not right. Some years ago we raised enough by subscription to put the Society out of debt. This might be done again, but it will not remedy the difficulty. If I am rightly informed the dues, if paid, are sufficient to publish our Transactions and meet other necessary expenses. I would therefore urge upon the Society the necessity of not burdening itself with the publication of the Repertory, at least not until our financial condition has improved.

I now thank you again for the honor you have conferred upon me in making me your presiding officer; I beg you to overlook my

mistakes and ask your help, so that the business may be carried on promptly and wisely, and that this session may be a very pleasant and profitable one.

On motion, a vote of thanks was tendered President Bingaman for his instructive and exhaustive address, and a committee of three was appointed to consider the address and the suggestions contained therein.

This committee consisted of Drs. E. C. Parsons, John E. James and Joseph E. Jones.

On motion, roll-call was dispensed with.

The annual report of the Treasurer, Dr. J. F. Cooper, was then presented, and was as follows:

REPORT OF THE TREASURER.

PHILADELPHIA, SEPTEMBER 17, 1890.

Paid Sherman & Co. for printing and issuing Transactions of 1888, as per bill,	$519 86	
" W. B. Trites's bill, printing and stationery,	6 50	
" bill of E. R. Snader,	44 22	
" H. Pitcairn,	9 75	
" H. Pitcairn & Dern,	40 75	
" bill of W. E. Hering,	101 75	
" bill of E. W. Eckel for Cor. Secretary,	5 00	
" envelopes and postage stamps for Treasurer's use,	11 00	
Balance due Treasurer at last Report,	348 47	
		$1087 30
Received since last Report as dues of membership,	$675 00	
" " " " assessment of 1888,	60 00	
Balance due Treasurer at this date,	352 30	
		1087 30

Respectfully submitted,

J. F. COOPER, M.D.,

Treasurer.

On motion this report was accepted and referred to an Auditing Committee consisting of Drs. C. Mohr, W. J. Martin and J. E. Jones.

The Committee, after due consideration, made the following

REPORT OF THE AUDITING COMMITTEE.

The undersigned committee appointed by the President to audit the accounts of the Treasurer report that they have found them to be correct.

We have examined the books, papers and vouchers of the Treasurer and find that his expenditures, as reported, were $738.83, and his receipts $735.00, leaving a deficit of $3.83 for the current year, which, added to the deficit reported last year, to wit, $348.47, leave a balance of $352.30 due the Treasurer.

C. Mohr, M.D.,
W. J. Martin, M.D.,
Joseph E. Jones, M.D.,
Auditors.

The Society then listened to the report of the Corresponding Secretary.

REPORT OF THE CORRESPONDING SECRETARY.

The Corresponding Secretary has to report that the issue of the Transactions for last year was somewhat delayed owing to some avoidable and other unavoidable circumstances. Several of the factors I shall briefly mention: Failure of the authors of papers read by title to forward the same to the Secretary; failure to return proof sent authors for needed correction; and the "grippe" attacking the employees of the establishment in which the publication was being effected.

The Secretary again desires to ask the members of the Society to make use of the card-order privilege entitling them to reduced railroad rates. A failure to make use of the privilege causes difficulty in securing reduced rates for subsequent years.

Respectfully submitted,
E. R. Snader, M.D.,
Corresponding Secretary.

On motion this report was accepted and referred to the Committee on President's Address for action.

The Committee on Publication, through Dr. Snader, reported:

REPORT OF THE COMMITTEE ON PUBLICATION.

Three hundred and fifty copies of the Transactions were issued, 158 of which have been delivered to members who have paid their dues and 13 to the Homœopathic medical colleges, 26 to the various journals, 1 to Hahnemann Hospital of Philadelphia, 1 to Pittsburgh Hospital, 2 to Ward's Island Hospital, 49 to State Societies publishing Transactions, 1 to American Institute of Homœopathy, 12 to honorary members, 6 to corresponding members, 1 to the State Library at Harrisburg, 1 to the Public Library at Washington, D. C., 1 to the Surgeon-General of the United States (by request), 1 to the Allegheny City Library, 1 to H. H. Crippen, 1 to Dr. Horner, 1 to Dr. J. F. Cooper, 1 to Trunk Line Commissioner (in the interest of reduced rates for the Society), making a total of 297 copies distributed (139 complimentaries), leaving on hand 53 copies.

E. R. Snader, M.D.,
J. F. Cooper, M.D.,
J. R. Horner, M.D.,
Committee.

On motion, the report was accepted.

The Committees on Legislation and State Regulation of Medicine, through Dr. C. P. Seip, made the following report:

REPORT OF THE COMMITTEE ON MEDICAL LEGISLATION.

Your Committee upon State Regulation of Medicine would respectfully report that they have considered the papers referred to it at the last annual meeting, as well as the general subject of State regulation of medicine, and recommend the following for adoption:

1. That we believe it to be the duty of the State itself to foster all medical advancement, and insure the highest and best possible medical education by direct supervision of all medical colleges within its boundaries.

2. That all medical examiners' bills are imperfect, however constituted, and fall far short of what is required, in that its most potent function is to limit the practice of medicine, and touches the real subject for which it is ostensibly put forward only secondarily, and, possibly, quite remotely.

3. For the above reasons, we are opposed to all medical examiners' bills, except the State should refuse to assume supervision of college work; then we should be in favor of a bill as amended by the Legislature of 1889, viz., that no one school or system of medical practice shall have a majority of the members upon the said board.

4. We recommend that the Legislative Committee be authorized and instructed to propose a bill covering the following suggestions: A board of education, consisting of one Old School, one Homœopathic and one Eclectic physician, and two laymen.

a. Its duty shall be to fix the standard of education required for admission to any medical college; to examine any who may not have reached the required standard; and certify as to their standing, before they can be admitted to any college.

b. To apply the same test of education to graduates from colleges outside the State, and certify his standing to any medical college within the State, who shall examine the applicant, and, if found worthy, then to endorse his diploma for registration under the act of 1881.

c. The board to have supervision over all medical colleges as to their minimum curriculum, length of time and number of courses of lectures, and the faithfulness of instruction imparted, under such penalty as may be provided.

d. The same committee to present said bill to the Legislature of our State, and use all diligence in securing its passage and enactment as a law of the Commonwealth.

C. Seip, M.D., *Chairman*,
John E. James, M.D.,
C. Mohr, M.D.

On motion, this report was adopted.

Dr. Samuel Long, President of the New Jersey State Homœopathic Medical Society was present, and, by unanimous vote, accorded the privileges of the floor.

The Committee on Treasury report that an investigation showing a large number of members in arrears, concluded to address a note to each one with a request to remit promptly to the Treasurer, and so relieve the Society of its indebtedness to Dr. Cooper, rather than appeal to those members who had already paid their dues for special

subscriptions. In response to the note quite a number promptly responded, and others found fault that they had been reminded of neglect of duty, while some ignored wholly the assessment of $2 levied on each member at the 1888 meeting.

We have taken into consideration the report of the Treasurer made at this session, have examined his books, and find that the active membership in 1888 was 271, of which number 163 paid the $2 assessment, leaving 103 members in arrears on account of the assessment, though many of these are not in arrears on account of annual dues.

Of the members now on the roll we find 48 who are in arrears for five or more years, and 170 members from one to four years in arrears.

Now we submit that, if these delinquent members would remit their dues, our Treasurer would have $1061, sufficient, therefore, to cover the deficit of $352.30, and leaving $708.70 to use in publishing the Transactions of the present session and other incidental expenses. In other words, we could pay all our bills and remain out of debt. We, therefore, believe we should not be required to solicit subscriptions to cover the deficit reported by the Treasurer, and submit the following recommendations:

1. That all members who are five or more years in arrears be furnished with a bill, a note appended showing the necessity for prompt remittance, and a notification that if not settled by January 1, 1891, their names will be dropped from the published list of members.

2. That the Treasurer be instructed to again send to all members on the roll prior to 1888, who have not yet paid the $2 assessment of 1888, a bill for this item with the bill for their regular annual dues.

C. Mohr, M.D., *Chairman*,
Joseph E. Jones, M.D.,
Z. T. Miller, M.D.,
Committee.

Dr. Pemberton Dudley, for the delegates to the American Institute of Homœopathy, reported a very successful meeting. A large number of new members had been elected. It was decided to meet

next year in connection with the Fourth Quinquennial Congress, at Atlantic City, N. J.; and he called the members' attention especially to this point.

Dr. Edward R. Snader, Chairman, made a report of the

BUREAU OF ORGANIZATION, REGISTRATION AND STATISTICS.

A tabulated statement of the reports received by the Secretary, in answer to an appeal, from the various hospitals and dispensaries in the State, is herewith transmitted (See pages 21 and 22).

The totals appended to the hospital report do not accurately represent the exact figures. For instance, 2292 patients are reported as having been treated in the hospitals. The Pittsburgh Hospital and Dispensary figures are mingled.

In the dispensary reports, only the number of prescriptions is given for the Pittsburgh Hospital, while they are omitted altogether from the report of the Children's Homœopathic Hospital of Philadelphia, and the Germantown Homœopathic Dispensary presents no figures whatever.

At the last meeting of the State Society the Bureau of Organization, Registration and Statistics, were asked to prepare blanks for the use of the hospitals and dispensaries, suitable for comparison with old-school statistics, in order to ascertain the percentage of cures.

One of the members of the bureau believes that the statistical blank of the American Institute of Homœopathy, slightly modified, would serve as the proper blank.

Such a blank would have the following headings:

Date of ending of hospital year.
Amount of endowment fund.
Amount of cost per patient per week.
Expenses.
Sources of income.
Amount of invested property.
Value of hospital and grounds.
Died.
Not relieved.
Relieved.

Report of Homœopathic Dispensaries in Pennsylvania.

NAME.	Where Located.	When incorporated.	When opened to patients.	Name and address of Secretary or Superintendent.	Number of patients treated last year.	Number of prescriptions given last year.	Cost of conducting dispensary last year.	Sources of income.
1. Hahnemann Medical College and Hospital Dispensary.	Broad Street above Race, Philadelphia.	1848	1848	William C. Hannis, Drexel Building, Philadelphia.	10,148	37,823	.....	Dispensary is sustained by corporation; included in hospital expenses.
2. Children's Homœopathic Hospital of Philadelphia.	914 N. Broad Street, Philadelphia.	1877	1877	N. B. Kelly, Pennsylvania Railroad Office, Philadelphia.	11,419	.....	.....	Charitable contributions.
3. Dispensary of the Medical, Surgical and Maternity Hospital of the Women's Homœopathic Association of Pennsylvania.	Twentieth Street and Susquehanna Avenue, Philadelphia.	1882	1884	Mrs. R. Weston, 210 S. Fourth Street, Philadelphia.	.....	8,089	.....	Voluntary payments for medicine.
4. Homœopathic Medical and Surgical Hospital of Pittsburgh.*	Pittsburgh.	1866	1866	W. D. Slack, Pittsburgh.	.....	17,358	Included in hospital expenses.	Same as hospital.
5. Homœopathic Dispensary of Germantown.†	Germantown, Pa.	.....	1877	Thomas Reading, M D., Hatboro.	.....	.....	.....	Germant'n Medical Club.
6. Allentown Homœopathic Dispensary.	105 N. 8th St., Allentown.	1882	1882	W. A. Hassler, M.D., Allentown.	572	2,812	$275.	Contributions.
					22,139	66,082		

* Hospital and Dispensary figures mingled.

† Closed for repairs.

Report of Homœopathic Hospitals in Pennsylvania.

Name.	Where Located.	When incorporated.	When opened to patients.	Name and address of Secretary or Superintendent.	Number of beds.	Number of patients treated last year.	Cured.	Relieved.	Not relieved.	Died.	Sources of income.
1. The Hahnemann Medical College and Hospital of Philadelphia.	Broad Street above Race, Philadelphia.	1850	1852	William C. Hannis, 536 Drexel Building, Phila.	30	426	297	74	13	22	Subscriptions, endowment fund, etc.
2. Children's Homœopathic Hospital of Philadelphia.	914 N. Broad Street, Philadelphia.	1877	1877	N. B. Kelley, Esq., Penna. R. R. Office, Walnut St. Wharf, Phila.	50	135	74	47	10	4	Voluntary contributions.
3. Medical, Surgical and Maternity Hospitals of Women's Homœopathic Association of Pennsylvania.	Twentieth Street and Susquehanna Avenue, Philadelphia.	1882	1884	Mrs. R. Weston, 210 S. Fourth Street, Philadelphia.	60	287	180	48	22	15*	Donations, subscriptions, small endowment fund and pay of patients.
4. Homœopathic Medical and Surgical Hospital and Dispensary of Pittsburgh.†	Pittsburgh.	1866	1866	W. D. Slack, Pittsburgh.	150	1,405	1,052	134	24	83	State aid, private patients and contributions.
5. Benedictine Sisters.	Erie, Pa.	‡	1876	E. Cranch, M.D., 109 N. Ninth Street, Erie.	10	39	30	8	0	1	Regular income of the Sisters in their own work.
					300	2,292	1,633	311	69	125	

No. 1, year ends April 30th; No. 2, January 1st; No. 3, January 31st; No. 4, September 8th; No. 5, August 1st.

* Five deaths occurred within eight days after birth, and one was still-born.

† Hospital and dispensary reports mingled.

‡ Not separately reported as an infirmary; belongs to the convent.

From the Pittsburgh Hospital 23 patients eloped or were expelled, and 89 remain in the hospital.

Cured.
Number of patients treated last year.
Number of beds.
Name of secretary, or executive officer.
When opened for patients.
When incorporated.
County.
Where located.

A blank for dispensary use would, following the same general plan as above, be as follows:

Name.
Location.
When incorporated.
When opened to patients.
Date of ending of dispensary year.
Name and address of executive officer.
Number of patients treated last year:
1.—Old.
2.—New.
Number of prescriptions.
Cost of conducting dispensary last year.
Cost per patient.
Amount contributed for support of dispensary.
Sources of income.

A much simpler set of blanks, for the purpose of comparing the number of patients treated, and the percentage of cures, are also herewith submitted for the selective action of the society, as follows:

Hospital Blank.

Number of beds.
Number of patients received.
Number of patients cured.
Number of patients relieved.
Number of patients not relieved.
Number of patients who died.
Number of patients removed.

Dispensary Blank.

Number of patients visiting the dispensary during the year.
Number of new patients during the year.
Number of visits made to patients at their homes during the year.

The Johnstown Dispensary, maintained for some time by the Hahnemann College Hospital, has been discontinued, there being no further necessity for its existence. A summary of the cases treated, prepared by Dr. H. E. Kistler, in charge of the dispensary from June 27 to December 31, 1889, is herewith transmitted:

Whole number of patients treated,	2340
Whole number of prescriptions made,	6055
Whole number of visits made to homes,	2791
Whole number requiring surgical treatment,	215
Whole number of deaths,	6

On or about October 1, 1890, the new Hahnemann College Hospital will be open for the reception of patients. The facilities for surgical work and for the medical care of cases will be unequalled.

Respectfully submitted,

EDWARD R. SNADER, M.D.,
Chairman.

On motion the report was accepted and referred to the Committee on President's Address.

Dr. Wm. J. Martin, Necrologist, presented his report.

REPORT OF THE NECROLOGIST.

MR. PRESIDENT:

Since our last meeting, one year ago, grim death has removed from our ranks four valued members. They were, in the order of their departure from this life:

JOHN MALIN, M.D.
WILLIAM B. TRITES, M.D.
L. B. HAWLEY, M.D.
THOMAS NICHOL, M.D.

These were all men who stood high in the communities in which they resided, stood high in the profession of medicine, and stood high in the esteem of this society.

JOHN MALIN, M.D., died November 29, 1889, at his home, Germantown, Philadelphia, Pa., aged 56 years.

Dr. Malin was born near Penn Yan, Yates county, N. Y., February 2, 1833; he was the second son of Dr. George W. Malin and Rosetta H. Malin. He finished his literary education at Franklin Academy, Steuben county, N. Y. He then studied dentistry, which he practiced for several years, and then took up the study of medicine with his father. He graduated from the Homœopathic Medical College of Pennsylvania (now the Hahnemann of Philadelphia) in 1860. He practiced his profession in Germantown, Pa., until about a year before his death. He had a large and laborious practice, and was more than ordinarily successful, and was very popular with his patients. His death was due in large measure to the exposures and hardships of a large practice.

He was a member of the American Institute of Homœopathy, was Second Vice-President of our State Society at its annual meeting a year ago in Pittsburgh, and was twice President of the Homœopathic Medical Club of Germantown. He left a widow and one son, also one brother, Dr. Wm. H. Malin, now practicing medicine at Chestnut Hill, Philadelphia.

WILLIAM BUDD TRITES, M.D., died at his home, Manayunk, Philadelphia county, Pa., January 19, 1890, aged 43 years. His death was due to pneumonia. During the late epidemic of "la grippe" he had an attack of the influenza, but the demands of a large practice caused him to neglect his own case to attend the calls of his patients, and he kept on his daily rounds—strong man that he was—until he was not able to leave his bed. In this condition he was taken with pneumonia. The vital forces were too much exhausted to withstand any severe attack of disease and he died, a martyr, truly, to his duty. Dr. Trites was born in Sunbury, August 22, 1846. He was the eldest son of Dr. David Trites. Until the breaking out of the rebellion the family resided in Virginia, and from there they came to Philadelphia and finally to Manayunk, and

remained there to the time of his death. His geniality and moral, upright nature made him exceedingly popular, both as physician and citizen.

He was President of the Homœopathic Medical Society of Philadelphia for three years. He was President of the Pennsylvania Homœopathic State Society, occupying the Chair at the annual meeting just one year ago. He was a member of the American Institute of Homœopathy, and contributed many and valuable papers to the societies of which he was a member; also a number of articles in Arndt's System of Medicine. For several years he lectured on venereal diseases in the Hahnemann Medical College of Philadelphia, and later filled the Chair of Pathology and Practice of Medicine during the absence of Dr. W. C. Goodno. From his early youth he was actively connected with the Mount Zion Methodist Episcopal Church. He was one of the originators of the Young Men's Christian Association of Manayunk, and for several years its President. He was chairman of the delegation sent by the Homœopathic Medical Society of Philadelphia to Harrisburg at the last session of the Legislature, to secure legislation in the interest of Homœopathy, and to his indefatigable labor, was due in great measure the defeat of the unjust Medical Examiners' bill that had been presented. Immediately after the Johnstown flood the 21st Ward Johnstown Relief Association was organized through the active exertions of Dr. Trites, who was made the president of the association.

Full of honors, though young in years, but few physicians are privileged to obtain so enviable a reputation as did Dr. Trites. The subtle character of the sympathy that went out from him was felt by every one who came in contact with him. All found in him a reliable friend, and an earnest worker in whatever he undertook. To do everything in the best possible manner was the ruling principle of his life.

Stricken down in the full vigor of his manhood, and with every prospect of a long and prosperous future before him, his untimely end will prove an incalcuable loss to his family, to the profession and to the community in which he labored so faithfully and so acceptably.

Beloved by all who knew him, he is gone, but his works still live.

Dr. L. B. Hawley died March 20, 1890, at his home in Phœnixville, Pa., aged 63 years.

Dr. Hawley was born in 1827. He graduated from the Homœopathic Medical College of Pennsylvania in 1853; consequently, he had been engaged in the practice of Homœopathic medicine for a period of thirty-seven years. In 1855 he located at Phœnixville. In 1863 he moved to Kinderhook, N. Y., where he remained but a few years, when he returned to Phœnixville, and continued in active practice there up to the time of his death. He was one of the organizers of the Chester and Delaware Counties' Society in 1858.

Dr. Hawley possessed, in a high degree, the natural qualifications for a successful physician; quick in perception, but cautious in utterance; warm of heart, but cool of head; ever ready to assist and stimulate to better efforts and nobler purposes. With a kindly charity for the weak and an appreciative fellowship for the strong, his silent presence was more potent for good than the eloquence of others.

In his death medicine has lost a liberal and loyal votary, and Homœopathy a worthy exemplar.

Thomas Nichol, M.D., died June, 14, 1890, at his home, Montreal, Canada, in the 60th year of his age. His death was indirectly due to overwork during the epidemic of "la grippe" last winter, when he broke down with symptoms of heart paralysis. With rest and care, however, his health was so much improved that by April he was able to resume work; but his trouble returned, and he unexpectedly died while sitting in his library chair.

Dr. Nichol was born in Edinburgh, Scotland, April 26, 1831. His father was a Presbyterian minister, and gave young Thomas a good Scotch education, and trained him up in the way that he should go. He served his time at the dry-goods trade in Scotland. At the age of twenty he came to Canada, where he taught school. In 1854 he began the study of medicine in the office of Dr. A. T. Bull, of London, Canada, graduating at the Hahnemann Medical College, Philadelphia, in 1857. He at once began practice in Simcoe, Ontario, and was married two years later. In 1865 he moved to Belleville, where he was made Professor of Physiology and Ethnology in Albert College. In 1870 he settled in Montreal, where he continued

to reside and devote himself to his professional duties up to the hour of his death.

At an early age Dr. Nichol evinced a fondness for reading, and all his life he was an enthusiastic student. His library, containing over 2000 volumes, was the pride of his professional life. He was a frequent contributor to our periodical literature and the author of a work on *Diseases of the Nares, Larynx and Trachea in Childhood.*

This Society, recognizing the high order of his literary and professional attainments, elected him a corresponding member in 1873. Since that time he contributed a number of valuable papers to our meetings.

Few men have enjoyed the honor of having so many titles conferred upon them as did Dr. Nichol. Besides his degree of M.D., which he received in 1857, he took the degree of LL.B. from Victoria University in 1874, and the degree of LL.D. in 1881. He also took the degree of B.C.L. at McGill University in 1875, and the degree of D.C.L. in 1887.

Dr. Nichol was a member of the American Institute of Homœopathy. In his death our cause has surely lost one of its ablest exponents and firmest adherents.

W. J. Martin, M.D.,
Necrologist.

On motion, the report was accepted and referred for publication.

On motion of Dr. Mohr the Secretary was instructed to send to the relatives of the deceased members a letter of condolence, together with a copy of the Transactions containing a report of the action of the Society.

The Board of Censors, during the session, reported favorably on the following applications for membership, and the gentlemen were unanimously elected:

Leon Ashcraft, Philadelphia, Pa.,	Hahnemann Med. Col., Phila, 1890.
Weston D. Bayley, Philadelphia, Pa.,	" " " 1888.
H. W. Baily, Atlantic City, N. J.,	" " " 1886.
H. D. Baldwin, Montrose, Pa.,	N. Y. Homœopathic Med. Col., 1875.
Isaac Cooper, Trenton, N. J.,	Hahnemann Med. Col, Phila., 18—.
Jos. M. Caley, Philadelphia, Pa.	" " " 1889.

Anna C. Clarke, Allentown, Pa.,	University of Michigan, 1890.
Anna E. Dumont, Philadelphia, Pa.,	Hahnemann Med Col., Chicago, 1887.
Nevins W. Fryer, Philadelphia, Pa.,	Hahnemann Med. Col., Phila., 1889.
J. G. Fickel, Carlisle, Pa.,	" " " 1879.
G. W. Gregory, Troy, Pa.,	Albany Medical College, 1879.
J. H. Hamer, Philadelphia, Pa.,	Hahnemann Med. Col., Phila., 1875.
C. H Hubbard, Millville, N. J.,	" " " 1881.
Edmund H. Kase, Philadelphia, Pa.,	" " " 1887.
F. W. Lange, Scranton, Pa.,	" " " 1890.
Lyttleton Lyon Lazear, Pittsburgh, Pa.,	" " " 1890.
I. G. Shallcross, Philadelphia, Pa.,	" " " 1887.
G. P. Stubbs, Philadelphia, Pa.,	" " " 1890.
Geo. A. Smith, Philadelphia, Pa.,	" " " 1876.
Wm. Spencer, Philadelphia, Pa.,	" " " 1887.
T. Hart Smith, Philadelphia, Pa ,	Homœopathic Med Col., Penna., 1866.
Walter Strong, Hahnemann Hospital, Philadelphia, Pa.,	Hahnemann Med. Col , Phila., 1890.
C. S. Stafford, Philadelphia, Pa.,	" " " 1889.
R. C. Smith, Philadelphia, Pa ,	Homœopathic Med. Col., Penna., 1869.
Geo. W. Titman, Philadelphia, Pa.,	Hahnemann Med. Col., Phila., 1883.
R. T. White, Allegheny, Pa ,	Homœopath. Med. Col., Chicago, 1886.

Mahlon Preston, M.D., Resigned.
Maria M. Johnston, M.D., Resigned.

REPORT OF THE BUREAU OF MATERIA MEDICA AND PROVINGS.

Address of the Chairman, C. S. Middleton, M.D.
" Beliefs Concerning Materia Medica," by C. Mohr, M.D.

REPORT OF THE BUREAU OF MATERIA MEDICA AND PROVINGS.

The Bureau of Materia Medica and Provings beg leave to report that, in accordance with the instructions of the State Society at the meeting in Pittsburgh one year ago, an effort has been made to complete the *Repertory of Hering's Condensed Materia Materia.*

Owing to the fact, however, that instead of the repertorial work growing in favor it has become quite unpopular; many of the collaborators and some of the members of the bureau failed to re-

spond to all efforts on the part of your chairman to have them continue their compilations. This unpopularity manifested itself at a meeting of the members of the bureau resident in Philadelphia some time before the meeting of the State Society in Pittsburgh. Knowing this fact your chairman was particular to have the Society give the bureau instructions for the coming year, which it did.

Notwithstanding this, a circular letter was issued as follows, and a copy sent to every member and collaborator, according to the list in Transactions of 1889.

To the Members and Collaborators of the Bureau of Materia Medica and Provings.

GENTLEMEN: At the meeting of the Homœopathic Medical Society of the State of Pennsylvania, held at Pittsburgh, September 17, 1889, the report of the above-named bureau was composed of several finished sections of the *Repertory to Hering's Condensed Materia Medica*, which were completed since the publication of the sections by order of the State Society of the year before.

In addition to the work above mentioned, the bureau presented several other papers and provings, which are of great interest and importance.

The bureau has been directed by the Society to continue the work on the Repertory, while at the same time the Society finds it impracticable to publish as fast as completed. On the other hand, the compilers are allowed to publish their work in journals if they wish, but they must retain the MSS. for the use of the Homœopathic Medical Society of the State of Pennsylvania whenever demanded.

I would therefore urge upon the members of the bureau and their collaborators to make a strong effort to complete this work, and have it ready to be placed at the disposal of the Society, which will meet at Philadelphia in September, 1890.

I would also urge upon the members who have completed the work assigned to them, (or even if they have not done so), to prepare some additional papers for the bureau, which shall be instructive and practical. We cannot have too much material of the right kind.

It is desirable that titles of papers with a synopsis of subject

shall be in the hands of the Secretary by August 15, so that they may be announced in the notice of the coming meeting.

A meeting of the bureau and its assistants will be held at my office in Philadelphia, Friday, March 21, 1890, at 8 o'clock P.M., to which you are cordially invited, and it is hoped you will be present. Any member being unable to attend will confer a favor by sending a concise report of the progress of his work.

Very truly yours,

C. S. MIDDLETON, M.D.,

1523 Girard Avenue, Philadelphia, March 1, 1890. Chairman.

Two other appeals were sent out during the course of the season, besides many efforts were made to secure original material for the bureau, not only from members in the State, but from outside locations, not excepting Canada and England.

I have the honor to present herewith the following finished papers of the Repertory and one original article:

"Repertory of Sensations," Dr. S. F. Shannon.

"Repertory of Face," Dr. Alfred Norris.

"Repertory of Cough," C. S. Middleton, M.D.

"Beliefs Concerning Materia Medica," C. Mohr, M.D.

C. S. MIDDLETON, M.D.,
Chairman.

BELIEFS CONCERNING MATERIA MEDICA.

BY CHARLES MOHR, M.D., PHILADELPHIA.

FOR a dozen or more years many Homœopathists have wondered why so little has been done in the distinctive branch of this school —the materia medica. In these years comparatively few provings have been made; contributions of materia medica papers to our journals have been few and far between; and at our various society meetings the Materia Medica Bureau reports have notably been the most meagre. Efforts to discredit our materia medica have not been wanting, and there have been quite persistent attempts made

at critical revision and condensation, which, if carried to the extent some would have us do, would make of our materia medica a disarticulated skeleton, a lifeless thing, of interest or value to no one. I would be the last to deny that our materia medica cyclopædias, text-books, manuals and repertories are redundant with errors of omission and commission, and I believe, therefore, in criticism, in revision, in analysis and in condensation, but only when the work is done with a view of providing us with a more reliable record of pure drug effects than we have heretofore possessed, so that our ability to cure disease will be increased.

Doubtless much of the indifference in materia medica work is due to the time and thought required to keep pace with the collateral branches of medicine, which during the past decade have been so marvellously interesting and enticing. Some indifference has arisen by reason of the censorial attitude of the revisers of our materia medica and their critics, and by the lukewarm manner of acceptance by the profession of the few provings that have been made. Much the greatest cause for indifference and neglect, however, I believe to have been due to the method of teaching materia medica in vogue in our colleges, too little having been taught and too much having been required to be learned in too short a time. Now that the three years' graded course has been adopted by all our schools, improvement in teaching will necessarily follow; more will be made, however, when a fourth year is added to the obligatory course of study. Then instead of having graduates go forth with a few hundred memorized "key-notes" or "characteristics," as their stock of knowledge of materia medica, they may have a foundation so stable, such a conception of the work before them, that they will take a pride in rearing an enduring, and as far as possible, a complete and faultless superstructure.

Ever since I began the study of medicine, my predilection has been for materia medica, and I have had the advantage of personal instruction from Hering, Lippe, Guernsey and Farrington; have been a close student of their writings, as well as of the works of Hahnemann, Dunham, Allen, Hughes, and a host of lesser lights in the Homœopathic school, and have likewise studied the works and method of teaching of such materia medicists as Phillips, Ringer, Trousseau, Pareria, Wood, Bartholow, Edes, Hare and others of

the Allopathic school. Careful observation of the result of their teaching, and the experience of my own efforts as a teacher for the past fourteen years, are a justification for laying before you my ideas in general of the method that should be pursued in imparting instruction in drug phenomena in health and disease, firmly convinced if that or similar methods were adopted by the teachers of materia medica in all our colleges, we would soon have a strong corps of workers who would give us reliable provings, enlarge our therapeutic resources, and aid in converting thousands of empirical prescribers in all schools of medicine into sound practitioners of Homœopathy.

Presuming that the student has had a preliminary education sufficient to enter the medical school, his studies during the first year should embrace medical botany; the recognition of vegetable, animal and mineral drug substances in their commercial or crude forms; the methods required (including practical laboratory work) to convert these substances into the most active medicinal forms; a consideration of the general effects on the healthy human body of material and toxic doses of the most commonly used medicines; how drugs are classified according to effects by old-school therapeutists; how drugs are administered, and what the maximum and minimum doses are, should also be taught. At end of term an examination should be held, and if satisfactory, the student is advanced to the

Second year, which should embrace medical chemistry; toxicology; method of proving medicinal substances; an explanation of their pathogenetic effects according to the known laws of physiology, the pathogeneses being presented, as far as possible, in narrative form, so that the sequence of drug phenomena is not disrupted. A satisfactory examination having been passed at end of term, the student is advanced to the

Third year, during which an analytical study of drug phenomena should be pursued, for which the student has been prepared by his previous training in anatomy and in physiology. The pathogeneses of the drugs, classified in natural orders and groups, should be presented as follows:

1. Objective phenomena, including general appearance; posture; expression and color of face; condition of integument, including temperature, perspiration, eruptions; condition of lymphatic glands of neck, axilla and groins as to size, hardness, mobility, tendency to

suppuration, etc. ; condition of locomotor system, including state of bones, muscles and joints.

2. Nervous phenomena, including mind and disposition ; condition of intelligence, sleep, headache ; condition of nerves of sensation and motion ; condition of special senses. Concomitants.

3. Circulatory phenomena, including condition of peripheral arteries and veins ; condition of pulse as to number of beats, character and variations ; condition of heart and large vessels within thorax, noting cardiac dyspnœa, palpitation, pains and sensations, etc. Concomitants.

4. Respiratory phenomena, including nose, action of alæ nasi ; condition of larynx and voice ; condition of trachea ; condition of lungs and pleura ; number and character of respirations ; dyspnœa ; kinds of pains and sensations ; cough ; character of expectoration ; hæmoptysis, etc. Concomitants.

5. Digestive phenomena, including condition of tongue, teeth, deglutition, appetite, thirst, digestion, character of pains and sensations, nausea, vomiting and state of bowels ; condition and pains and sensations referable to liver, spleen, stomach and intestines. Concomitants.

6. Urinary phenomena, including frequency of micturition ; pains and sensations before, during and after micturition ; changes in the quantity, color, reaction, specific gravity, odor of the urine, and the chemical and microscopical character of all deposits. Concomitants.

7. Genital phenomena, including condition of the male organs, coition, etc., and in women frequency, duration and quantity of menstrual discharge ; condition of mammæ ; condition of mucous membranes, of vagina and uterus, with character of discharges, pains and sensations ; effects of coition ; abnormal conditions during pregnancy and lactation. Concomitants.

8. Changes in function and tissues of any part of body not included in above-enumerated physiological system.

The student having passed a satisfactory examination on the studies of the third year, and become acquainted with the natural history of diseases and pathology, is advanced to the

Fourth year, which is devoted to a consideration of the therapeutic application of drugs. Antipathic, Allopathic and Empiric uses are duly considered, the greatest care being exercised to teach

the Homœopathic application. As far as possible, the diseases to be treated are classified under the physiological systems, such as nervous, circulatory, etc. This teaches the student to be methodical, brings to mind the symptoms taught previously and makes them appreciate what is really pathological and to be cured. But a strong point must always be made as to the necessity of investigating every deviation from the normal in every physiological system before prescribing, for the *Homœopathic* drug must cover the *totality*—not the symptoms of a named disease alone, but the symptoms of that disease and all others of the *man*, whether they bear a relation to the disease to be treated or not. During this year comparisons of the most similar drugs in diseased conditions are instituted, and the reliable clinical symptoms are taught. At end of this year the student gets his final examination in materia medica and therapeutics, which should be thorough.

I believe the student who has graduated after the course of materia medica training I have thus hastily outlined, will never lose interest in the subject. He will have something tangible, reasonable and systematic, and be inclined to enlarge the field. After graduation he should be taken under the fostering care of our county, State and national societies, and induced to prove drugs to the fullest possible extent, every safeguard being used to prevent errors creeping into the recorded drug effects. The records should be published by our societies in day-book or the narrative form in every instance, copies of which should be lavishly distributed and co-operation invited, so that the pathogenesis may eventually become complete.

We need not wait the adoption of a four years' obligatory course by our colleges before putting into practice the training of physicians in materia medica as suggested in this paper. We can work up papers with the materials already accumulated, and present them for review, criticism, alteration and additions to our societies. Re-provings can be made, and should be made persistently, to enable us to present drug effects in the narrative form. Our colleges can adapt the general features of the plan I have given to the existing three years' obligatory course.

DISCUSSION.

Dr. August Korndœrfer, in opening the discussion, said he doubted if it was a wise course to devote so much time to physic-

logical materia medica to the exclusion of the symptomatological. Many symptoms cannot be classified according to their physiological relations. Many of the pathological conditions which we think we understand to-day we find ourselves ignorant of to-morrow. If the studies of the physiological action of drugs are so conducted as to make prominent the peculiar characteristics of the same according to Hahnemannian doctrines, as obtained from provings, then we have attained the highest type of instruction. Students should learn the effects of the crude drug that they may antidote them. They should learn also the genius of drugs.

This is best gotten by first obtaining the physiological action, and the superstructure is built by a thorough knowledge of the symptomatology. Any system which belittles symptomatology brings about the deterioration of the ability as a prescriber of the person so studying.

For years there has been a cry of tares. For years the speaker has been waiting for a harvest. In the meanwhile, he has been doing a little harvesting for himself, and he thought this was the plan all should follow, but, at the same time, we should lay up a store for others.

Dr. Mohr believed that the teaching of characteristics could be pursued more profitably during the second than during the first year. If the so-called key-notes are taught students at first, they become negligent of the other points. They think when they have learned the key-notes that they have acquired a knowledge of the drug.

Dr. M. S. Williamson thought that it would be a good thing if students were not taught a single symptom until they were well-grounded in the collateral branches. They must know something of the action of crude substances. Diagnosis should certainly precede the study of materia medica, for then only can we know the value of symptoms. After the student has acquired a knowledge of crude doses, then he can take one more step.

Dr. Korndœrfer said that Bœnninghausen made many cures, and yet his knowledge of diagnostics and pathology was not up to that of the present day. The same was true of Jahr, Hahnemann and Hering, and yet no one dare stand here and say that they know more of materia medica than those old men who knew so little of the

pathology that we know to-day. These studies are necessary to our students, but they should be regarded as collateral. Are mistakes in diagnosis made more frequently by Homœopaths than by Allopaths? It was the speaker's experience that great mistakes were made by the so-called great pathologists of the old school. Men well versed in the study of symptomatology are far better fitted as diagnosticians than are the men educated in the physiological school of to-day.

Dr. Pemberton Dudley said that pathology had its uses and its abuses. He was a strong believer in the value of pathology, but he did not approve of pathology being made a basis for prescribing. The correct use of pathology to the Homœopathist is that it enables him to get the totality of the symptoms. The very fact that we are better pathologists to-day enables us to get a better totality than could be obtained in Hahnemann's day, and so makes us better Homœopathists. As to diagnosis, the mere name of a disease covers but a few cases. The same remarks that have been made respecting the genius of drugs applies to the genius of cases.

Dr. Charles Mohr said that he used the term pathology in the sense given by Dr. Dunham, namely, "sick physiology." He thought that we must appreciate not only the anatomical lesions, but also every deviation from the normal standard of health.

Dr. A. P. Bowie did not think that the members of this Society knew as much as Hahnemann did, for Hahnemann had a far better idea of materia medica, based on his knowledge of drug provings. If we work with one-tenth of Hahnemann's zeal, we would hear less talk of the imperfections in materia medica.

Dr. Dudley said that if his remarks were offensive, he would withdraw them.

THE REPORT OF THE BUREAU OF CLINICAL MEDICINE.

Address by E. C. Parsons, M.D., Chairman, Meadville.

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REMARKS AT THE OPENING OF THE BUREAU OF CLINICAL MEDICINE.

BY E. C. PARSONS, M.D., CHAIRMAN.

Ladies and Gentlemen of the Homœopathic Medical Society of Pennsylvania and Members of the Bureau of Clinical Medicine:

It gives me no little pleasure to meet you on this occasion, and I take this opportunity to give expression to a feeling of personal pride in the honor conferred upon me by our late President in the selection of your Chairman for the present session.

Our Society has gained the reputation, which it justly merits, of being *one* of the best, if not *the* best, of State societies in point of effective work.

The Bureau of Clinical Medicine has not been an unimportant

adjunct in enabling this organization to secure this honorable reputation. Is it not, therefore, pardonable for one to evidence some little feeling of personal pride and exhilaration to have been thus highly honored? While the choice of another might have been wiser and the labor performed more efficiently, I can assure you that the duties imposed have been no drudgery, but rather a source of enjoyment and pleasure.

As we are thus permitted to exchange greetings, and before beginning the report of the Bureau, we are reminded that the occasion is not one of unmixed joy.

Since our last meeting one of our number and a very useful member of this bureau, W. B. Trites, late President of this Society, has been removed by death, which is not only a private sorrow, but a great loss to the public and to the medical profession. We miss his earnest and hearty greeting, his commanding presence and dignified bearing. Personally, Dr. Trites was social, modest, cultivated and generous. His contributions to this bureau were always interesting and instructive. He loved his fellow-men. This was evidenced by the very expression of his face, the tone of his voice and the warm and friendly grasp of his hand. I think I voice the sentiment of all in my presence who knew him when I say that he possessed unquestionable goodness of soul and noble, generous instincts, which were natural to him in part, perhaps, but elevated by religious culture. We may well emulate his example in our efforts to advance Homœopathy and the science of medicine, as well as in the development of strong and manly convictions and a pure and noble character.

Since our last meeting there has been a very general epidemic, both in this country and in Europe, which has served to diversify and enlarge the clinical experience of the past year. Perhaps no epidemic has caused so many deaths in such a brief period. It has been estimated that in less than two months twelve thousand people died from this disease as a direct or indirect cause. The epidemic was usually regarded and designated as la grippe or influenza, but the very general absence of catarrhal manifestations, such as redness of the eyes, lachrymation, discharge from the nose, sore throat, dry, spasmodic cough, with stitching chest pains, and the presence of severe and often agonizing pain in the head, back, muscles and

joints, together with much intolerance of light and sound, and in many cases pain in the epigastrium, with nausea and bilious vomiting, besides the very generally abrupt invasion, the high temperature at the beginning, and the presence in not a few of the cases of an eruption, variable in character, some lesions of which resembled erythema and others urticaria, and frequently enlargement of the superficial lymphatics, the development occasionally of abscesses and boils during the period of convalescence, and the extreme prostration common to all, would rather lead to the conviction that the disease was not influenza, but rather a modified form of dengue or break-bone fever. This is all the more probable when we remember that dengue had been prevailing in Southern Europe just prior to the outbreak of this epidemic in Northern and Central Europe. Be this as it may, it is demonstrated again that while it is desirable and important to diagnose correctly, that it is not absolutely essential to the selection of the proper similimum and the successful cure of many forms of disease. Homœopathy has again been brought into comparison with old-school methods, and has withstood the critical test in a commendable manner, and to the great satisfaction of its votaries. The use of such remedies as aconite, arnica, belladonna, bryonia, gelsemium, mercurius, nux vomica, phosphorus, rhus tox. and many others, when selected and given in accordance with the symptomatic indications, was attended with results much more satisfactory in promptness of action and in the avoidance of serious complications and sequelæ than was secured by the methods adopted by old-school practitioners in the use of antifebrine, antipyrin, sulphate of quinine, sulphate of morphine, spiritus frumenti and other antithermic, narcotic and stimulating drugs.

In concluding these remarks I wish to express my appreciation of and gratitude for the very general support this bureau has received from my associates in the preparation of papers for the present session.

Of the fourteen associates, ten have responded to the call for a paper appropriate for this bureau. Two papers are very kindly volunteered, which, including my own, make thirteen in all. Of the remaining four associates, two, Drs. H. Pitcairn and C. C. Rinehart, have sent letters of regret and furnished good and satisfactory

reasons for their failure to contribute at this time to the interest and work of this bureau.

Hoping that the papers presented will merit your interest and that you are all "loaded to the muzzle for the discussion," that not only a *number*, but *all* "of the papers will elicit," we will proceed at once to the reading of the papers as announced in the programme.

REMARKS ON THE DIAGNOSIS OF ABSCESS OF THE BRAIN WITH SPECIAL REFERENCE TO THE QUESTION OF TREATMENT.

BY CLARENCE BARTLETT, M.D., PHILADELPHIA, PA.

In 1886, Dr. J. Orne Green, an eminent old-school authority on diseases of the ear, writing concerning the treatment of abscesses of the brain following aural diseases, said:

"The result of abscess of the brain is invariably fatal. Of treatment nothing can be said."

These few words about represented the opinion of the great majority of the profession at that time. The great obstacle to successful treatment was the inability on the part of the physician to diagnose the presence and the position of the abscess, and the fear of the surgeon to explore the sacred cavity of the cranium. In 1888, Dr. Roswell Park, of Buffalo, in a paper read before the Congress of American Physicians at Washington, on "The Surgery of the Brain as Based on the Principles of Cerebral Localization," presented a general review of what had been accomplished in the realm of cerebral surgery. Sixty-seven cases of operation on the brain were reported in abstract; of these, fifteen were cases of abscess of the brain, eight of which recovered, and seven died. While the percentage of recoveries is not as large as we would like, still it is sufficiently great to show that the surgical treatment of cerebral abscesses has a future before it. Without operative interference, all of these cases would have certainly died.

Since Park's paper appeared, numerous other cases have been re-

ported, the mortality among which has been large. In most of them the operation was postponed until destructive changes had progressed so far as to preclude all possibility of a recovery. This was so in the case reported by me in the *Hahnemannian Monthly*, for May, 1890. From the character of the wall of the abscess, it was plain that the disease had existed several months at least. The large area of softened brain-tissue surrounding the encapsuled abscess made the case a hopeless one.

The main difficulty, therefore, in the treatment of brain abscesses, has been, and is yet, one of diagnosis. Given a positive diagnosis that an abscess exists in a certain locality of the brain, and the indications become clear. Unfortunately, positive data are not always available. While in the majority of cases it is possible to recognize the existence of the abscess, still the diagnosis is generally based on what would in the courts be called circumstantial evidence, aided by a process of exclusion.

The object of the present paper is to present as briefly as possible a review of the data on which a diagnosis of cerebral abscess is to be made, together with such as have a bearing on the question of treatment.

In the examination of suspected cases no circumstance, however apparently trivial, should be neglected. The onset of the disease is generally insidious, especially so in those cases following suppurative disease of the middle ear. In fact, the more insidious the advent of the trouble, the more likely it is to be a case of abscess, and the less likely to be one of the other intracranial complications of aural disease, meningitis and sinus thrombosis, for example.

First and foremost, the ætiology of abscesses of the brain must be borne in mind. At the present day, it is generally conceded that idiopathic abscess of the brain is an impossibility. All cases of cerebral suppuration must result from one of the following causes:

1. Traumatism.
2. Middle ear suppuration.
3. Tuberculosis.
4. Metastasis.

Tubercular abscesses are almost certainly beyond the aid of surgical skill, so that their recognition becomes a matter of but little practical moment. The entire removal of the cheesy infiltration of the brain is impossible, and the portions remaining after the opera-

tion would only renew the suppurative process. More than this, tubercular processes of the brain are almost invariably associated with extensive tubercular changes in other organs, especially the lungs. Metastatic abscesses afford but little opportunity for help, for they are rarely single. Like the tubercular, they are associated with extensive pathological changes in other and important organs. Cases arising from traumatism and aural disease are the only ones that can be reached by surgical treatment. Fortunately, these constitute fully nine-tenths of all cases. It is to them that my remarks are intended to apply.

The history of a previous injury in an obscure case of brain trouble becomes then a very important matter. It apparently makes no difference whether the traumatism be severe or light; abscesses have followed the most trifling and the most severe. Von Bergmann insists upon but one universal characteristic of these injuries, namely, that the external integument be broken. It is not necessary that the cranial bones be fractured, or their fibrous covering injured. The solution of continuity of the integument is the only prerequisite. Pitt, on the other hand, makes an injury to the bones themselves, the *sine qua non*, and thinks that slight injuries have but little influence. Sight must not be lost of the fact that Pitt bases his observations on cases seen in Guy's Hospital, all of which were brought in suffering from severe injuries, and in whom the abscess developed almost immediately on the reception of the traumatism. Even though the brain substance be severely contused, no abscess will result, according to von Bergmann, if the integrity of the external integument be preserved. The time after the receipt of the injury at which the abscess takes place varies greatly in individual cases. Abscess never appears under two weeks after the accident. This is an important point as it serves to differentiate abscess from meningitis and encephalitis, two affections presenting a confusingly similar symptomatology to abscess, but both of which come on immediately after the exciting cause. All cases of cerebral abscess do not follow so closely on the reception of the injury. Damer Harrisson has reported a case in which the abscess was not recognized until eleven years after the blow that gave rise to it. The usual interval, between the injury and the appearance of cerebral symptoms, in case the latter do not come on within a few weeks, is from three months to a year.

Ear disease, it is now generally conceded, is responsible for nearly one-half of all cases of cerebral abscess. The portion of the auditory apparatus, disease of which causes brain complications, is the middle ear, and never the internal. It is worthy of note that middle ear suppuration very seldom causes brain abscess until it has existed for a long time, for months at least, and generally for years. Park says that acute suppurative otitis media never occasions cerebral abscess; but Bergmann in his valuable monograph quotes one such case, which proves the possibility of the occurrence. Brain complications supervening on acute otitis media are almost invariably cases of meningitis or sinus thrombosis.

In some cases traumatism seems to combine with the aural suppuration to excite brain abscess. Thus, the latter has been known to occur shortly after the receipt of a severe box on the ear, or even after the operation of opening the mastoid cells. In this connection I must express my opinion concerning the methods of performing the operation. Chiselling cannot but jar the entire head; the concussion thus produced, may increase existing cerebral inflammation or start an inflammation that had not already existed. The mastoid trephine, on the other hand, opens the cells without any shock whatever.

The importance of these two factors in the ætiology of brain abscess, traumatism and suppurative otitis media, must be ever borne in mind, for the symptomatology of the disease is such as to give us but little light in their absence. These symptoms may be classed under the following heads:

1. Symptoms due to the suppuration itself.
2. Symptoms resulting from the increased intracranial pressure.
3. Symptoms resulting from the destruction of certain structures in the brain, and varying with the locality of the lesion. These are the so-called area symptoms, or localizing symptoms.

Among symptoms of the first group may be mentioned increase of temperature. This point is insisted upon very strongly by von Bergmann, while Nancrede and others affirm that in cerebral abscess, the temperature is almost always sub-normal. Pitt says that pyrexia is rare in uncomplicated cases, and that when the temperature is high, and the initial rigor marked, thrombosis of some of the cerebral sinuses has taken place. Sir Wm. Stokes likewise regards a perfect apyrexia as consistent with the presence of a cerebral abscess. Bergmann contends furthermore that in some cases, at least,

the temperature on the affected side is greater than that of its fellow. He cites a case in point in which the difference between the two sides was 1.8° F. The value of the thermometer in the diagnosis of cerebral abscess thus becomes a question of dispute. Each observer has in all probability had the misfortune to see but few cases of this disease, and their observations must of course have a limited value. Cases of uncomplicated abscess have been reported in which the temperature fluctuated from 103.5° F. to below normal.

Admitting fever to be a not infrequent symptom of cerebral abscess, its value is somewhat lessened in cases following aural disease, for we must first assure ourselves that it has not arisen from extension of the inflammation to the mastoid cells. In all cases in which an accession of fever points to brain disease, and surgical procedures seem indicated, the exploratory trephining of the cranium should be preceded by the opening of the mastoid. The latter being found healthy, other sources of inflammation must be sought.

The pulse is usually frequent. It only becomes slow in advanced cases when the abscess is large, and intracranial pressure correspondingly great.

The symptoms arising from the increased intracranial pressure are essentially the same as those present in cases of brain tumor. They are, however, characterized by their insidious onset. In fact, the more insidious the mode of onset, the more likely are the symptoms to be due to abscess as compared with meningitis and thrombosis. They may exist for months and years, without giving rise to a suspicion as to their real nature. Prominent among the pressure symptoms stands headache. This is apt to be not as severe as in the case of tumor. It is variable in its intensity. Its most important modality is its tendency to exacerbation with the rise in temperature, at which time the pulse rate may fall. Pitt makes the peculiar observation that the headache accompanying abscesses from disease of the middle ear is apt to be more severe than that in the case of abscesses coming on from other causes. The explanation of this is to be found in the fact that abscesses consecutive to otitis media are usually large, and the intracranial pressure is correspondingly great. As in the case of brain tumor, the pain may occupy almost any relation to the seat of disease, though usually near the lesion. Other pressure symptoms are drowsiness, unconsciousness, coma, Cheyne-Stokes respiration, and slow pulse. All of these

may come on to a marked degree and then disappear almost entirely, thus deluding physicians into the hope that recovery is about to ensue, and that the diagnosis of brain abscess was a mistake.

Optic neuritis which is so frequent a symptom of brain tumor is rarely found in uncomplicated cases of cerebral abscess. Pitt notes its presence in but two of the uncomplicated cases of his series; while he found it almost invariably present in cases of sinus thrombosis. He therefore draws the conclusion that optic neuritis does not favor a diagnosis of abscess. When present as an accompaniment of intracranial suppuration, it is never as severe as in tumor. It may even be limited to but one side, that on which the abscess exists.

The symptoms arising from the special location of the abscess in the brain are of but comparatively little value, except in those cases in which the symptoms point to disease of the motor areas. Abscesses in the frontal, temporo-sphenoidal, and occipital lobes, rarely give rise to area symptoms. The special symptom supposed to accompany disease in the occipital lobe, is hemianopsia, and yet in but one instance of abscess in this location, has this disturbance of vision been noted, in the case reported by Janeway. The infrequency with which abscesses give rise to area symptoms is to be accounted for by the fact that the suppurative process is of slow growth; the consistence of the abscess is such as to make an equable pressure in all directions; its substance being soft, the pressure exerted is not so injurious as it might otherwise be; and lastly the abscess is usually situated in the white substance of the brain, a portion less important from a physiological standpoint than the gray matter.

Were we to rely then upon the localizing symptoms we would fail very frequently in diagnosis. Fortunately, a study of the ætiological factors at work in each case is of value in this connection. Toynbee laid down the rule that disease of the middle ear was liable to be followed by abscess in the temporo-sphenoidal lobe; while in cases in which the mastoid process is involved, the intracranial suppuration will be found in the cerebellum. This law is not infallible. It is simply a statement of the usual sequence of events. McBride and Miller make the further observation that when the auditory nerve is involved, the suppuration is probably beneath the tentorium. When the auditory nerve is not affected, the abscess is probably in the temporo-sphenoidal lobe.

Experience teaches that nearly nine-tenths of all cases of cerebral abscess consecutive to aural disease attack the temporo-sphenoidal lobe. Of seven cases observed by Barr six were thus located, while the seventh was beneath the dura mater in this locality. This author makes the estimate that 75 per cent. of all cases of abscess following aural suppuration are to be found in the temporo-sphenoidal lobe. All of these can be reached by a trephine opening made at a point one inch and a quarter behind and one inch and a quarter above the external auditory meatus. And this I think should be the seat of operation in every case unless localizing symptoms call positively for some other point of attack. In the majority of cases of abscess of the temporo-sphenoidal lobe area symptoms are absent, as above stated. A large portion of its structure may be destroyed without interfering with a single cerebral function. An exploratory operation in suspected cases can then do no harm. In cases in which the localization is in doubt, this portion of the brain may be explored first, as it stands operative interference better than any other portion. The increased intracranial pressure produced by the abscess exerts its influence on distant parts, so that we may expect the corresponding hemisphere to give evidence of impaired function. In my case, to which reference has already been made, the existence of hemiplegia was wrongly taken to indicate an abscess high up, pressing on the motor areas. The autopsy showed that the abscess was in the temporo-sphenoidal lobe, and that the pressure came from below. I think, therefore, that in view of the frequency of involvement of these lobes, one is justified in ignoring area symptoms when they are of an indefinite character, and making an exploratory operation in this region. In some cases local tenderness is a valuable guide. It is especially apt to be present when the dura mater is inflamed.

Abscess of the cerebellum is not very frequently attended with area symptoms. The localization of the lesion in this position must be made by a process of exclusion. The suppuration usually involves only a lateral lobe, disease of which is at present regarded as being incapable of giving rise to a definite symptomatology.

As for traumatic abscesses, area symptoms have not, so far as I am aware, aided in the localization of the affection in a single case, aside from those in which the speech centres or the motor areas have been involved. Many abscesses arising from traumatism have been operated successfully, but the surgeon's guide in nearly all has been the

scar, or some such local sign. While the cicatrix may, in many instances, be a good guide, it is not infallible, as the abscess may have originated from contre coup, and may, therefore, be found in a portion of the brain far removed from the seat of injury. As in the case of other abscesses, the onset is insidious. In early cases the only sign ofttimes consists of peculiar behavior of the wound, which suppurates more than usual, or if there be a compound fracture, there is escape of pus from beneath the fragments. The early abscesses are generally superficial, while those coming on late are almost invariably located in the deeper structures of the brain. The latter it is certain are not the result of bruising of the brain substance, for should that organ sustain a bruising so severe as to extend thus deeply it is almost certain that death would soon follow. In all cases it is a significant fact that long-continued suppuration of the external wound favors the abscess formation. This is a practical point by way of prophylaxis, as it impresses one with the importance of rigid antiseptic measures in the treatment of all scalp and head injuries.

In the case of brain symptoms coming on during the course of aural disease one must not lose sight of the fact that vertigo, high fever, clouded intellect, and even convulsions and delirium, may all accompany otitis media acuta, and yet these serious symptoms may all disappear promptly after incising the membrana tympani and giving vent to the confined secretions. The symptoms in such cases are the result of increased intra-labyrinthine pressure.

In closing, I cannot avoid impressing upon my audience the importance of resort to operative measures in every case of cerebral abscess. Untreated, they all end in death. Prompt action, on the other hand, saves a goodly number of cases. The cases of this character observed by each physician are few in number. Rarely does a practitioner see but one such in all his experience. Many escape them altogether. Few as these cases may be in individual experiences they are in the aggregate great. It is estimated that nearly one hundred people die annually in London alone from brain affections consecutive to aural disease. What the exact number is in the large cities the world over I do not know; but I am satisfied that it is by no means small. In light of the almost certain death under any other course, I feel that no case should be allowed to die without some effort to save him by operation.

DISCUSSION.

Dr. W. B. Van Lennep said that he had seen but two cases of abscess of the brain, both in conjunction with Dr. Bartlett. One of these has already been reported in the *Hahnemannian Monthly*. In the last case, owing to the absence of symptoms pointing to the location of the abscess, it was deemed inadvisable to trephine. The scalp was raised over the seat of injury in the hope of finding a crack in the bone, but no opening was found, so that further operative measures were abandoned. The patient presented all the symptoms emphasized by Dr. Bartlett. The brain symptoms came on late after the injury, and the external wound was associated with a great deal of suppuration. With regard to the other case, the one reported in the May *Hahnemannian*, Dr. Van Lennep said that he wished to impress upon the audience a point that had not been sufficiently insisted upon hitherto, and that was the possibility of the walls of a cerebral abscess being most remarkably tough. Usually the abscess walls are quite soft. But in this case they were so tough as to give him the impression, when his probe touched it, that he had reached the tentorium. The patient, when operated upon, was in such a condition as almost to preclude any possibility of recovery. In a future case, the speaker thought he would not hesitate to use greater force in his efforts to penetrate the abscess walls, even at the risk of penetrating the tentorium.

A CASE OF REMITTENT FEVER, WITH HÆMORRHAGIC COMPLICATIONS, AND REMARKS CONCERNING THE DIFFERENTIAL DIAGNOSIS OF REMITTENT AND ENTERIC FEVERS.

BY G. MAXWELL CHRISTINE, M.D., PHILADELPHIA.

The two fevers, remittent and typhoid, having in their gross or superficial aspects some features in common, it has been suggested that I make a case which came under my notice and which aptly illustrates this statement, the subject of a paper for this Society. I

am furthermore prompted to do so, because, upon the surface it has enough features about it to warrant, seemingly, the diagnosis of typhoid fever, and not that which was made—remittent fever with hæmorrhagic complications.

The differential diagnosis of these two diseases is an easy one in typical cases; but disease, of whatever character, will not always assume the typical character, and hours, and days, and sometimes years, will be spent in anxious watching for such a grouping of disease-manifestations as will permit us to know their source. Not every disease-manifestation is open to the senses of the observer, but it often remains hidden, for, as year after year goes by, and the various helps to diagnosis are given to the physician for his use, we find these hidden symptoms coming forth to be matters of knowledge. Ignorance, as applied to medicine, is a comparative term, for it will never be in the grasp of man to know all concerning disease, and we censure, and will be censured, for errors in diagnosis according to the light given us by which to be guided. Our knowledge concerning both remittent and typhoid fevers is, no doubt, environed within narrow confines, particularly appearing to be so when we conceive of the possibilities of future investigations. Whilst within the past decade, in particular, a certain and considerable progress has been made respecting these fevers, it is likewise true that they have not been rid of that mystery which has ever puzzled, and for long time will continue to puzzle, the physician; and therefore, to a proportionate extent, baffle his treatment.

The question naturally arises in this connection: Will a period ever arrive when, by some means certainly not now definitely and absolutely known, disease will be identified at the hour or day of its inception, or even at any time during its course? If such a fortunate period ever does arrive, it will be when the disease-cause is possible of identification. At present, we must be content with little more than the accumulation of symptoms, and in their grouping and analysis, with the approximate determination of their cause. Bacteriology has, undoubtedly, taken the advance step in this disease-individualization. Even now, bacteriologists claim to be able to arrive at a true knowledge of the nature of disease in their asserted discovery of bacteria special to many diseases, and microscopists present strong claims for having done much toward the identity of

disease. If they have succeeded in so doing, even in one disease, they have materially added to the power of the physician over disease.

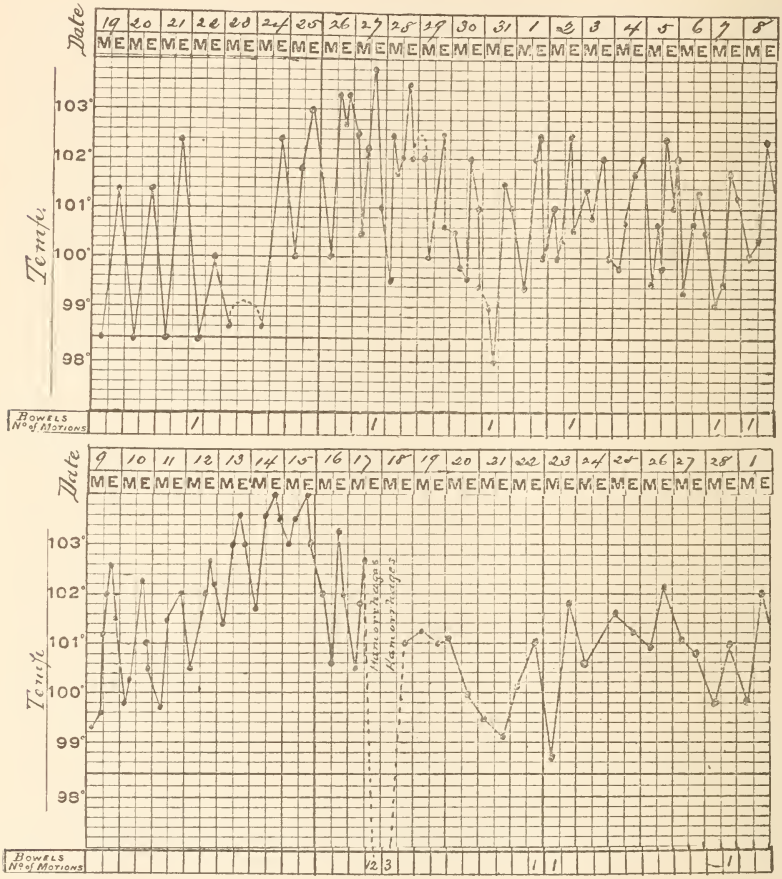
A. B. C., a lad of thirteen summers, lived, in the year 1888, in a house which had been condemned by the Board of Health on account of sanitary defects. Together with a companion, my patient played, as boys will do, in the yard of the house, digging the soil, though it gave off with every shovelful the odors of the contained fæcal discharges which a long while before had escaped from the privy-well into the earth. While at Lake George, in 1888, he developed malarial symptoms, which lasted indefinitely throughout the summer and fall months into the winter. In the middle of December, he he was in bed with an attack of follicular tonsillitis, which lasted several days. After this, he was comparatively well until January 17th, when he went to bed with a fever, for which, for a few days, he was given home remedies. On the 19th I was summoned. There was a history of a chill at noon, followed by a sweat, with complete intermission in the mornings, upon which basis I made a diagnosis of intermittent fever. For six days after I had been called, the intermissions continued, when they gave way to remissions. From this time forward the disease continued for six weeks.

Following is the chart of the temperature and bowels. No record of the pulse is given in the chart, that being below 100, even at the time of the highest fever, except at the period of hæmorrhage.

As we study the chart no difficulty will be experienced in comprehending the intermittent character of the fever up to the 23d, the type being quotidian. The temperature was almost normal on the 24th, and in the P.M. may have been above normal, as on previous days at a corresponding hour. The temperature was nearly normal on the morning of the 24th, also, but in the P.M. there will be noticed a rise took place to $102\frac{2}{5}°$. Up to this point, a period of seven days under my care, and of three or four days previous, the fever was decidedly intermittent. During this time, reference to the nurse's memoranda shows the pulse to have been from 90 to 100. The appetite was good; the bowels were constipated, moving once under an injection; the boy's spirits were good, and the noon chill, while marked, was not severe.

On the morning of the 25th there was, contrary to expectation, no

intermission of the fever, but a temperature of 100° took its place, increasing to $102\frac{4}{5}$° at noon, and to 103° in the P.M. The next day there was a similar rise of the morning fever and a higher evening



fever. The morning remission and evening exacerbation continued with more or less variation until the 30th, when there was a decline in the fever both morning and evening. The temperature went down to 98° on the morning of the 31st. But, thereafter the fever continued to the 4th of the next month (February), when it again began to show an inclination to abate; but on the 8th it again began to rise in the P.M., continuing at about 100° in the A.M. until the

12th, when it began steadily to rise both morning and afternoon. This rise of temperature continued until the 15th.

This gives the fever curve for four weeks of the lad's sickness. I will pause here to relate the other symptoms from the period of first remission.

Had the thermometer not been used during this period, from January 25th to February 12th or 13th, the detection of fever would have been impossible. The skin was natural and generally moist. The tongue was moist and slightly coated, and of a bluish-gray color. The eye was bright; the cheeks rarely flushed; the pulse ranging at 100, of good quality and volume. There was no delirium, sleep was good, and the lad usually awakened in the morning refreshed. The appetite was good, but it was kept under bounds, the diet being a "typhoid regimen." There were no tympanites, no right iliac fossa tenderness, and no tenderness at any part of the abdomen except on the 28th, when slight tenderness existed in the left abdomen over the colon. On the 27th, the lad vomited curdled milk; the urine had a specific gravity, at this date, of 1022; no albumin. On the 29th the patient was remarkably bright, the pulse was 88, and the prospects for a speedy resolution were good. On the 30th, the bowels moved by injection; fæces were dark in color, but of normal consistency, and had no offensive "typhoid odor." The pulse was 80 on February 2d; the bowels were again moved by injection. On the 5th, the patient complained more than usual of chilliness. Bowels moved again on the 6th; fæces normal in odor, dark in color and normal in consistency. Pulse 88 on the 11th; bowels moved this day by injection. On the 12th, vomited about half-ounce of bile, and vomited again in two hours thereafter. I had a consultation on this day with Dr. A. R. Thomas. On the 14th, vomited half-cup of bile; no albumin in the urine; pulse 100. On the 15th, the urine was dark and slightly albuminous, and had shreds of blood in it; there was cough, with slimy and slightly bloody expectoration, and there was a profuse sweat; the tongue was slightly dry and brown (the first departure from the moist blue-gray character it had ever before assumed).

The diagnosis of the disease up to January 25th was easily made of intermittent fever, but on the cessation of intermissions there had to be a differentiation established between typhoid and remittent

fevers. Careful and laborious examination was made for the purpose of establishing an identity of the disease with typhoid fever, but the tests failed in every respect. In nearly every particular, however, the diagnosis of remittent fever was supported. In this diagnosis Dr. Thomas agreed. In support of this diagnosis was the following: Non-conformity of the fever-curve with the typical typhoid fever-curve, or with any undoubted typhoid fever-curve; the beginning intermittent, and subsequent remittent, character of the fever; the absence of delirium and all other nervous phenomena; no "dull, heavy, throbbing, persistent frontal headache; twitching of muscles; tickling of throat; ringing in ears; deafness; mind stupid;" no bleeding of the nose; no abnormality in the quality of the pulse; no uniformity in the fever manifestations; no sordes; no trembling of the tongue nor coating on it characteristic of typhoid; urine non-albuminous, heavy, as usual in malarial conditions; no diarrhœa, but constipation, the stools normal in character, at times bilious; no tympanites, but abdomen depressed; gastric disturbance, and the little one-day-existing abdominal distress referable to the colon; no splenic involvement; vomiting of bile; no rose-colored spots nor sudamina.

Yet, beginning with the 12th, the morning and evening fever steadily arose, and there was sufficient justification in the inquiry as to whether the case was not typhoid, masked or modified. But on the 16th and 17th, improvement became marked in some respects, and the diagnosis was still made of remittent fever. On the first of these dates there was vomiting of bile, with gastric and hepatic uneasiness. In the evening the nurse reported the pulse to have weakened for awhile and the patient to have been restless, an unusual symptom. The next day, the 17th, Dr. Thomas and I found the pulse good in volume but frequent, difficulty in voiding urine, and vomiting of mucus and bile. In other respects, the lad appeared to do well, though the fever stood, at 12 M., at $102\frac{3}{5}°$. The abdomen was still depressed, and no uneasiness was manifested in that part.

At 2 o'clock of the same day, however, a large hæmorrhage of the bowel took place without warning, another at 4.20, and others at 4.38, 6, 7, 7.30, 8, 9, 10, 11 (P.M.), 1.45, 2 (A.M.), and three others at hours not recorded, making a total of fifteen. Collapse became

profound, and the utmost and prolonged efforts at resuscitation were necessary from the time of the first hæmorrhage to several hours after the last, to save the patient's life. The lad rallied, however, and on the 6th of March had the last symptom of fever.

These intestinal hæmorrhages had been inaugurated by slight evidences of blood in the urine for several days, and by streaks of blood in the expectoration. It is in these hæmorrhages that the case is so interesting, furnishing one of those cases which, while purely malarial in character, have one symptom commonly associated with typhoid fever and apt to put doubt upon the diagnosis of malaria. The hæmorrhages in this case were doubtless due, not to glandular changes, but to mucous congestion, a common symptom in malarial fevers of prolonged issue, but one not frequently of the magnitude and fortunate result described above.

DISCUSSION.

Dr. W. C. Goodno said that he thought that those who attempted to diagnose typhoid fever on the temperature curve will meet with disappointment. In this country, at least, we do not meet with the so-called typical curve. Many cases begin with an intermittent fever, passing on to the remittent form, the fever finally becoming continuous. Then other cases may begin in the typical way and present the above-mentioned changes towards the close. In some cases the diagnosis can be made by the microscope. In remittent fever the blood is laden with hæmatin crystals. In typhoid fever the discharges from the bowels contain the bacilli of typhoid fever.

Dr. W. G. Dietz said that about three weeks ago he had been called to a case that gave him considerable difficulty in diagnosing. The patient had been under Allopathic treatment for one week. On inquiry of the husband of the patient, the doctor was informed that for some little time she had had fever and headache. She was lying on her back with face flushed. She gave a phthisical history, and a strong family history of tuberculosis was obtained. She was drowsy. On further inquiry the head pain was found to have been located for some time in the region supplied by the left supraorbital nerve. The temperature was 101.6 and the pulse 78. The tongue was perfectly clear. There was no tympanites, and there was a suspicious gurg-

ling in the right iliac fossa. He was unable to decide whether he was dealing with typhoid fever or tuberculosis. The patient was decidedly constipated, and it was necessary to relieve her bowels with an enema. She had no appetite. The next day her temperature was 103.5° F. and the pulse 92. It was of good strength and regular. The spleen was enlarged. The patient was extremely weak. She had been under treatment for a cough of long standing. She had night sweats and other symptoms of a progressing tuberculosis. The gurgling in the right iliac fossa persisted for several days with this difference, that the temperature rose one evening to 103.8.° In eight days the spots made their appearance on the abdomen. On the tenth day the bowels became loose. The remedy given her was cinchona 1m, after which the diarrhœa improved, and she made a rapid convalescence.

Dr. G. Maxwell Christine said that he had submitted enough samples of blood and fæces to microscopists for examination to make him very skeptical of any diagnosis that might be made thereby. In his case the abdomen was decidedly flat, and there was a marked hæmorrhagic tendency. The morbid anatomy of remittent fever is the same as that of the intermittent form, except that there is a difference in degree of intensity. In remittent fever we have congestion of the mucous membranes, and to that he ascribed the nose-bleed. He believed that some of the blood discharged in his case came from the small intestine, because when passed it was very dark and had undergone extensive changes. He did not believe that we could always diagnose typhoid fever by the temperature. But when we have a case with a decidedly intermittent temperature curve lasting for a week, we cannot have typhoid fever as a sequence, and, other things being equal, we should make a diagnosis of remittent fever. It has been said that a trace of blood in the urine is pathognomic of malarial fever. When we find a case differing in so many particulars from the essentials of typhoid fever, it seemed to him that the only diagnosis possible was remittent fever.

Dr. W. C. Goodno said that he had not pretended to make a diagnosis in Dr. Christine's case. He believed that it was an established fact that typhoid fever had its special bacillus. It is also well known that in protracted cases of malarial fever there is marked decomposition of the blood. The coloring matter is separated, accu-

mulates in the smaller capillaries, and, as a result of the obstruction of the circulation, these hæmorrhages occur, and not as a result of any special congestion. He did not think it possible to make a diagnosis with the microscope in every case, yet it was a valuable aid in many doubtful cases.

EPITHELIOMA OF THE FAUCES—CURE.

BY CHANDLER WEAVER, M.D., FOX CHASE, PHILADELPHIA.

In the latter part of December, 1889, the Rev. G. H., during a conversation on a railway train, inquired of me whether Homœopathists had any drug which would relieve the pain of cancers. My answer was that we had, by remedies, not only relieved, but cured, cancers.

On the 31st of December he called on me, asking for *palliative* treatment. A well-known throat specialist of the old-school had been treating him for over six months. Remedies were given internally, while locally a powder and electrolysis were used once a week. In December, 1889, the physician acknowledged his inability to prevent the growth of the cancer, and stated that death was but a question of time and might come very soon. He advised the local application of cocaine before eating or talking, and if this did not afford relief the internal use of morphia also. He assured the patient that this was all that could be done to allay his suffering; that he might as well try to enjoy his remaining days on earth.

In 1889 a portion of the uvula had been sent by the physician in charge to Drs. Tyson and Smith, of the University of Pennsylvania. After a microscopic examination they both pronounced it a decided case of epithelioma.

History.—Seventy years of age; strong and healthy; had had very little need of a physician previously; came from a good old Quaker family, with no history of syphilitic disease; married, had had one daughter, who died of typhoid fever in her twentieth year. He had been a Methodist minister for forty-five years, and had just

built himself a home that he might retire from the pulpit; of good habits, did not use tobacco in any way, or irritating drinks.

In May, 1889, he had a severe inflammation of the posterior part of the roof of the mouth, including the soft palate and tonsils. After I had treated him for a month without giving much relief he consulted the specialist of the old school. No ulceration appeared while I had him under treatment at that time.

The ulceration started from the tonsil and spread up and across to the uvula, half of which was eaten away; a strip from three-eighths to six-eighths inch wide, reaching from the uvula across the roof of the mouth to the base of the tongue and the left tonsil, which was included in the ulcerative process, was denuded, with a dirty, grayish-red base, having ragged edges, with a high grade of redness gradually fading from the edges. This is what I found when he returned to me in December, 1889.

The patient's diet had to be soft, smooth food, not very hot, and before attempting to swallow he was obliged to brush the throat over well with a 4 per cent. solution of cocaine. A similar application was necessary before talking, and several times during the night. So great was the pain he likened it to the "continual picking and scratching of a thousand red-hot needles."

When he left the Allopathic physician he applied to me for *palliative* treatment only, saying jestingly, "There is no use of your trying to cure when Dr. —— said it was impossible." I tried to encourage him by saying that I would certainly try to do more than merely relieve.

From his age and the character of the pains I put him on arsenicum 3x dilution, 10 drops on No. 30 pellets (sufficient to last him one week), six to be taken every two hours; I also directed him to blow a little of the 4x trituration on all of the denuded parts every two hours. This treatment was continued until January 21, 1890, except from January 10th to 13th, when he had the la grippe, when the medicine was changed to gelsemium, in water, every hour.

On January 20th I privately consulted Dr. Horace F. Ivins, who suggested that I now follow the arsenicum album with calendula. The general debility and rest at night were improved after being under the influence of arsenicum album for seventeen days. I began with calendula, 5 drops on No. 30 pellets (sufficient for one week),

and gave instructions to take six every two hours. I also gave him for one week (at Dr. Ivins's suggestion) a 20 per cent. solution of calendula with water to use as a spray upon the cancer.

January 28th.—The improvement was more marked, the inflammation was subdued, and the parts granulating very nicely. Calendula was continued as before.

February 4th.—Uvula healed entirely, and healing process continuing across the roof of the mouth toward the side. Treatment continued.

February 11th.—All healed down to tonsil. Up to this time I had allowed the use of a 4 per cent. solution of cocaine brushed over the denuded surface. This was done as seldom as possible, and only that he might eat with more ease. Calendula was continued every three hours, both locally and internally.

February 17th.—Tonsil nearly all healed, a place about one-fourth inch square remaining at the lower end. Calendula continued, as during the week before.

February 24th.—All healed, but some of the new tissue was still slightly high-colored. Same remedy every four hours.

His strength was sustained by a diet of eggs, milk, cream, oat-meal, rice, beef-tea, oysters, mashed potatoes and milk toast. Three times a day during the ulceration process he was given a tablespoonful of brandy, or beaten eggs in milk.

As the cancer healed in the reverse order from which it began ulcerating I believe the case cured.

March 10th.—All the parts that had been affected were natural in color and perfectly painless. He can now eat anything, and talk without the slighest difficulty whatever. The voice, however, is somewhat different in tone since the appearance of the cancer.

June 9th.—Since writing the foregoing the Rev. G. H—— returned to the Allopathic specialist, who, after a careful examination, pronounced it cured, and said he could see no evidence of a return, nor did he believe it would give further trouble.

DISCUSSION.

Dr. W. C. Goodno said that if there was any fact certain it was that the vast majority of cases of malignant disease do not get well.

The few that do recover make us suspicious of the diagnosis. In many of these chronic superficial ulcers there are many characteristics which are similar to those of epithelioma. The microscopical characteristics of the latter are epithelial tissues invading the deeper structures. A number of years ago, Dr. C. M. Thomas had made some investigation as to microscopical appearances of the walls of sinuses, and they had invariably found these epithelial cells making their way into the deeper structures. In many of these cases, therefore, it is difficult to make the diagnosis by the microscope alone. He would not detract one iota from the interest of Dr. Weaver's case, for he thought that a splendid cure had been made.

Dr. Chandler Weaver said that a number of physicians and specialists had examined the case and all had agreed as to its diagnosis. A syphilitic history was carefully excluded.

Replying to a question by Dr. T. J. Gramm, Dr. Weaver said that there was no glandular involvement.

Dr. W. B. Van Lennep said that he would not detract in any particular from the splendid cure made by Dr. Weaver, yet he would call to mind the possibility of diagnostic error. He had but recently seen a case of so-called epithelioma in which the clinical picture was perfect. The microscopic examination did not give as clear cut a picture as did Dr. Weaver's case. Nevertheless there were quantities of hard connective tissue, epithelial cells—in other words, there was a low grade of inflammation with more acute inflammation superficially, such as might be produced by irritants, and a very strong possibility of cancer. A probable history of syphilis was obtained. The patient was placed on the iodide of potassium, and in a few weeks that so-called cancer had disappeared entirely. He made these remarks for the purpose of endorsing the medicinal treatment of so-called cancers. But he would not like to see drawn from Dr. Weaver's case the generalization that would lead us to rely exclusively upon our medicines for the treatment of cancers. Should we keep on with the use of our remedies until infiltration of the surrounding tissues has taken place the case will then be beyond the reach of the surgeon's knife.

CURE OF STRANGULATED HERNIA WITHOUT OPERATION.

BY JOSEPH E. JONES, M.D., WEST CHESTER.

RECENTLY I was called in haste to see the five-year-old son of Mr. H. B., who was suffering greatly with a strangulated hernia of the left inguinal region.

The hernia had been produced some months before by the child falling down stairs, but heretofore was readily reducible at any time by lying down. This time it was different. It remained out in spite of position or effort of any kind. I found taxis of no account, but caused much suffering, and although the boy bore the distress with great patience, nothing could be accomplished. The gut still protruded as much as before the attempt at its reduction had been made, and there seemed nothing to be done but to open the sac surgically.

This was stated to the boy's parents, who pleaded most earnestly that everything should be tried before that resort. Hours had been consumed in fruitless endeavors, and the reduction must be accomplished soon or dire results would speedily follow.

The boy was resting on a lounge which had a high arm or end to it. This suggested a change of position, with the hope that gravity would aid in the reduction, so turning the patient around and taking away any pillow from under his head, his limbs were drawn up and over the arm of the lounge until the body of the patient was at an incline of at least 45 degrees. Then taking some ether and mixing with it about one-fourth of its volume of tincture of arnica with which a cloth was saturated and placed over the tumor, which was permitted to remain, occasionally being remoistened.

During this interval I was called away from the case, but on return found that the child had slept some, yet the enlargement did not seem to have lessened any in size, still was not quite so tender on handling it.

Various remedies had been given internally, but we could see no result from them. He continued to take nux vomica during this interval.

Again the patient rested another hour in the same position of body, with the same external application, and with a slight softening of the enlargement and more comfort to the child. About this time, while he was in this inclined position, I used, not taxis, but gentle pressure and rubbing in a direction to remove from the hernia any liquid or gas which might be confined in the knuckle of the gut, very gently gravitating it back into the unconstricted intestine. This added much to the patient's comfort and somewhat more softened the hernia. Same application continued.

Thus, late at night, he was left until the morning, with nurse force enough to watch him every moment of the time. He slept much of the night, and in the morning was devoid of pain and the tumor very much softened, the little fellow not complaining of the uncomfortable position, but accepting the necessity of it without a murmur.

About noon that day, nearly twenty-four hours after the violent symptoms of strangulation had commenced, the nurse in attendance heard the usual gurgling of the gut returning to the cavity of the abdomen, and the child was cured.

A proper truss was applied, and with ordinary care there is no doubt but that the hernia will be *permanently* cured before he passes two more years of his life.

This was a case of *violent* strangulation, and the urgency of its symptoms indicated an early operation necessary to save the life of the patient.

While the ether and arnica soothed the pain and excessive soreness of the parts, correcting the injury caused by the continued taxis, gravity was the main remedy in its relief. I cannot conceive how the application of the solution or the giving of the internal remedy could possibly have resulted in the good that followed if the position of the body had not been such as to permit the drain of the gases and liquids from the constricted pouch.

Of course, there may be another factor in the return of the displaced part, after the partial evacuation of its contents, that is, the drawing by gravity of the intestines in the cavity of the abdomen on the piece within the strangulation. This is a continued taxis with a correct application of the force, not from behind, which fills up the stricture yet more, but while lessening the bulk of the con-

stricted gut, draws it gently away from the sac, lessening the amount of the strangulated part.

Will not others try the same plan, and report its success or failure to this Society?

Discussion.

Dr. E. C. Parsons said that he had a case similar to that of Dr. Jones in a young man aged seventeen years. A number of unsuccessful efforts at reduction had been made. He finally accomplished his purpose by the application of hot fomentations, and the adoption of a position similar to that described by Dr. Jones.

CLINICAL NOTES ON THE USE OF ALSTONIA CONSTRICTA.

BY W. G. DIETZ, M.D., HAZLETON.

Case 1.—Miss M., æt. 23, came under my care four years ago, with the following history: Has always been a pale, delicate girl, subject to frequent fainting spells. Commenced to menstruate at 14, without much trouble, and has continued to do so regularly ever since. Had frequent attacks of suddenly losing her voice. Had been under Allopathic treatment for long periods.

Status quo at the time she came under my notice.—Pale, emaciated; complained of great debility; weak feeling in abdomen accompanied by a dragging sensation as though everything would escape through the vulva; nausea mornings on getting up; has to lie down again to prevent vomiting; frequent fainting spells, especially after her menses. Very despondent; thinks she will die. The pale face flushes up from the least excitement (has taken iron *ad nauseam*). Appetite always poor; the food seems to remain undigested in the stomach for a long time. Tongue coated white, with very red edges. Frequent attacks of cramps in the stomach after midnight. Diarrhœa of undigested food, immediately after eating; has to leave the table before finishing her meal (ferrum). Urine normal, specific

gravity 1018, acid reaction, and neither albumin nor sugar. Frequent attacks of palpitation.

I commenced the treatment with pulsatilla, and gave successively sepia, lilium tigrinum, aletris, sulphur, aloe, and natrum muriaticum, giving each remedy a fair trial, with varying success, relieving symptoms for a time, but they would reappear again with renewed force; so that, at the end of a year, my patient was not much, if any, better than when she came under treatment. I now put her on alstonia constricta 1x, a dose every three hours. In a short time improvement manifested itself, and continued uninterruptedly, so that at the end of another year she had changed from the pale sickly girl to a stout healthy woman. Only occasionally does she feel a return of the dragging sensations in her abdomen, but a few doses of the remedy always relieve her.

Case 2.—Miss S., æt. 22, about four years ago, while nursing a near relative during a prolonged illness, commenced to be troubled with a yellowish-brown leucorrhœa, very weakening, and this was soon followed by a dragging and bearing-down sensation in the uterine region, making walking quite painful, and at times almost impossible; great deal of lumbar backache; shooting and throbbing pains; at other times an aching in the right ovarian region, which was painful on pressure. Menses dirty-brown, accompanied by cramping pains in the uterus, and always preceded by diarrhœa. Has been treated by a noted gynæcologist in one of our eastern cities, who made local applications of Churchhill's tincture of iodine, and employed other similar measures, without, however, producing any lasting beneficial results to the patient, who came under my care about a year ago, with the above symptoms still persisting, and, in addition, complaining of great debility, with nausea in the morning on awakening. She presented a florid appearance, was fairly well nourished, and has always enjoyed an excellent appetite. Physical examination revealed a greatly anteverted uterus, cervix eroded, with the objective symptoms of endocervicitis. Tenderness in the right iliac fossa was present. Aletris, calcarea phosphorica, belladonna, kreosote, and nitric acid, all seemed to benefit the case, without, however, bringing about a radical change for the better. About three months ago, I put her on alstonia constricta, which she has taken steadily ever since, with the following

result: The morning nausea left her very soon; the dragging sensation and bearing-down in hypogastrium, as well as the leucorrhœa, have well nigh ceased entirely. In fact, with the exception of the pain in the right ovarian region, which remains the same, she considers herself nearly well. The diarrhœa, also, did not make its appearance before the last menses. The uterus, although movable, remains in its anteverted position.

Case 3.—Mrs. G., æt. 28, mother of three children. About a year ago, during prolonged lactation, she commenced to have sore, aching pains about the heart, with great soreness of the gastric region, which is sensitive to pressure. She came under my observation about two months ago, with the following symptoms: Constant distress in the region of stomach, a feeling as though something was lying there which should be removed, worse a few hours after meals. Occasionally, an empty gone feeling in pit of the stomach. Sharp, shooting pains, extending from the left side of the stomach through to the back. At the moment she falls asleep, she starts up suddenly, becomes wide awake, with violent palpitation of the heart and throbbing in the bloodvessels, accompanied by a numb sensation of the tongue Pulse 84, soft, compressible. Patient looks thin and pale, and has had many family cares and been overworked. After taking alstonia for six weeks she informs me that she is entirely relieved of all her symptoms.

Case 4.—Mrs. W., æt. 56, ill-nourished, scrawny-looking, complained for some time of great weakness, especially mornings. Empty, gone feeling in stomach, < towards evening. A sore, swollen feeling in right ovarian region; dragging-down sensation in hypogastrium. Has taken lots of Allopathic mixtures. Alstonia cured promptly.

Case 5.—Miss K., æt. 25, marked brunette, very active. Has complained, off and on, for years, of a dragging sensation in the uterine region. For the last six weeks, frequent attacks of nausea, with empty, gone feeling in the pit of the stomach, generally brought on when exerting herself. Alstonia relieved the latter symptoms at once, and there has been no return since.

Case 6.—Mrs. B. æt. 32, a hardworking woman, of rather small size, though fairly well nourished, and the mother of four children, the youngest three years old; has suffered from simple prolapsus

uteri for years; otherwise, enjoys good health, except occasional attacks of intercostal neuralgia; bearing down, with weak, empty, gone sensation in the pit of the stomach. Aletris relieved at first, but the symptoms returned—and it failed to benefit the case. Gave alstonia, which speedily relieved her, and there has not been a return for nearly a year.

I could cite *more* cases, but the above will suffice to call attention to a remedy which will prove useful in a class of disorders, especially in those peculiar to women, which frequently prove quite rebellious, even under the most carefully-conducted treatment.

In the absence of extended and reliable provings, and by the light of my own experience with this remedy, I consider the following symptoms as characteristic for its employment:

1. Great debility, with loss of appetite and weak digestion. Tongue generally coated a dirty white, especially toward the base, although it may be clean. Debility appears to be the key-note for the employment of this remedy, if dependent on a lack of digestive power on the part of the stomach, or else, assimilative power of the system at large. In debility of a purely nervous type, it has failed entirely; nor has it proved of marked benefit in the prolonged depression following severe cases of la grippe.

2. Nausea, < mornings before breakfast, or at irregular times, especially when depending on reflex irritation due to disturbances of the pelvic organs. I have not, as yet, given it a trial in the nausea and vomiting of pregnancy, but shall do so at the first opportunity.

3. An empty, gone feeling in the stomach, or else the whole abdomen, coming at irregular times, and associated with bearing and dragging down sensations in the hypogastrium.

THE CLINICAL SIGNIFICANCE OF ALBUMINURIA.

BY W. C. GOODNO, M.D., PHILADELPHIA.

It is but a few decades since albuminuria was of doubtful meaning. But Richard Bright and his co-workers and successors demonstrated its dependence upon nephritis in some form with such

clearness and conclusiveness that, from a symptom of doubtful or unknown meaning it has become the clinical corner-stone of that once obscure, but now well-defined, group, so appropriately designated Bright's diseases, Bright's diseases being simply the various forms of nephritis, acute and chronic. The great importance of albuminuria as an indication of nephritis has led to exaggerated estimates of its constancy in this affection, as well as of its exact clinical significance. So firmly has the idea that albuminuria means Bright's disease become fixed in the professional mind, that the terms have become almost synonymous, many authors even using them interchangeably. In view of this, we cannot wonder that diagnoses of Bright's disease are still, in most instances, made with the test tube only, and that the majority of general practitioners diagnosticate negatively or affirmatively after this test alone has been applied.

Considerable light has been shed upon this subject of late by our renal specialists, but there is much to be made clear, as well as a necessity for an increased corroboration of the results obtained by recent investigators. We know enough to-day, however, to say in no uncertain tones: Albuminuria does not mean Bright's disease and Bright's disease cannot be diagnosticated by albuminuria alone. Just what it does indicate it is the purpose of this paper to inquire into. I will relate the histories, briefly, of a few cases, which constitute the basis of some conclusions and hypotheses to be stated at the close.

Case 1.—Gentleman. Officer in a large corporation, 36 years of age, has been under my care for some five years past. At that time, desiring to increase his life insurance in a certain company, he was required to submit to a urinary analysis. To his consternation their examiner reported "albumin and casts." His application was of course rejected. This brought him to me, his family physician. Scores, perhaps hundreds of analyses of his urine, by myself and others have been made since that time with the result of finding an almost constant albuminuria. Generally, the ring of albumin developed by the cold nitric acid test is about as thick as a nickel five-cent piece. Rarely, it has been absent for a day or two or during some portion of a day, especially in the morning. The quantity is increased by unusual exercise and certain articles of diet.

At least fifty times (I speak thoughtfully) have we made careful search for casts, using various methods, with negative results, except in one instance, when a long, slender transparent cylinder of the so-called mucous variety was discovered, a form sometimes found in the urine of the apparently healthy. I have sent the urine to experts with the request for a careful examination, but with the same result. Degenerate renal epithelia and other indications of kidney disintegration have not been discovered. The urine is clear, amber, normal in quantity, and the average specific gravity, based upon a number of 24-hour collections, was about 1022. Few men are as free from symptoms of any character indicating ill health. During the past two years the amount of albumin has been decidedly less. Longer periods of remission have also been observed. Quantitative analyses, as well as the specific gravity, showed the solids to be present in normal quantity. Cardio-vascular changes cannot be detected and the ocular fundus is normal. There is unusual freedom from lithæmia for a man of his character and habits.

Case 2.—A large, apparently healthy lawyer, æt. 49, doing hard work in his profession, came under my observation about seven years ago. He represented to me at that time that he had had Bright's disease for several years, but seemed indifferent as to its seriousness. He was accustomed to the examination of his own urine, and stated that albumin was never absent, although the quantity was generally small. My own tests subsequently showed a constant albuminuria, *i.e.*, daily, but occasionally absent from the morning urine. Sometimes after intense work, such as an exciting criminal case, the amount of albumin present during the latter hours of the day was quite large—by the cold acid test the ring being the thickness of two five-cent nickel pieces. The specific gravity varied from 1018 to 1026; quantity fluctuating from 50 to 60 ounces; color often high. Repeated examinations failed to show tube-casts. Lithæmia was quite marked; ocular fundus was normal; the heart's action seemed rather strong, pulse rather hard, but hardly sufficiently so to warrant a diagnosis of cardio-vascular changes. There was some degree of gastric catarrh, but the patient's habits relating to his stomach were thoroughly bad, as were all of his habits. The patient had urethral stricture of large calibre, several points of contraction being discoverable. A No. 30 French sound could be passed. Decided gleet

was absent, a simple glueing of the meatus occurring. There was no evidence of catarrh of any higher portion of the urinary tract. Such a source of the albuminuria could be positively thrown out, as it existed prior to the primary urethritis. This gentleman came to me for the treatment of his urethral condition, having been told nothing could be done for his Bright's; to live properly and prepare to meet his end. An albuminuria of at least ten years finds this patient enjoying quite good health, free from any other signs or symptoms of nephritis.

Case 3.—A man, æt. 40, a conductor upon a horse-car line, called upon me several years since (1885), complaining of some loss of flesh, debility, pain in the back, etc. An examination of the urine demonstrated albuminuria, a well marked ring forming upon the cold nitric acid. Repeated examinations showed the quantity to be exceedingly variable and entirely absent, at times for several days. Careful observation upon the part of the patient developed the apparent dependence of the albuminuria upon the ingestion of albuminous food, quantities of nuts, or highly-seasoned food; and also, in some degree, from exercise. No other evidence of Bright's disease could be secured. Correction of diet, and regular, light exercise diminished, but did not remove permanently, the albumin from his urine. Disappearance of a catarrhal dyspepsia, due especially to more careful selection of food and the hours of partaking of it, seemed to be the reason of the relief of the general symptoms complained of.

Case 4.—A young lady, æt. 22, has enjoyed good health. Had scarlatina at 10 or 12 years of age, and typhoid fever at 17. Seemed to recover her health, however, after each disease in a normal period of time. Complaining of backache, her urine was examined, in pursuance of a general principle, rather than with the expectation of finding renal disease. The examination revealed a trace of albumin. The color, percentage of solids, and specific gravity were all normal. Leucorrhœa was not acknowledged. Nor was there catarrh of any of the mucous membranes. The vascular supply to the cutaneous and mucous surfaces is large, her color is high, and there is a disposition to bleed from small wounds. The albuminuria was distinctly intermittent, it being absent for days at a time, then present at every test for a longer period. The color was rather high, specific gravity 1022

to 1028; quantity rather scant. Several unsuccessful searches for casts were made. Constipation has been a very troublesome symptom. There was little change in the urinary condition during some eighteen months this lady was under my observation. I have not heard of her for two years past, until during the preparation of this paper. She states, in a letter from another city, that albumin was discovered by her medical attendant through a period of several months after passing from my care; but feeling well, she has paid no further attention to the subject during the past year.

Case 5.—A gentleman, 63 years of age, came under my care some five years since complaining of retention of urine. Examination revealed an enlarged prostate gland. The retention had just occurred, but had been preceded for some time with more or less difficulty in urinating. An occasional use of the catheter, with antiseptic precautions, relieved him much, but in spite of this relief his general health failed, flesh, appetite and strength diminished. The stomach was irritable, the tongue coated, then irritable, red, raw, cracked. Nausea troubled for a time, then vomiting. Cardio-vascular changes were apparently somewhat developed. The urine when first examined was 1015, 60 oz., no albumin. Subsequent examinations were more carefully made, when the stomach and other symptoms could not be accounted for upon any other hypothesis. Through a period of several months examinations were frequently made, the specific gravity averaging from 1015 to 1005, the quantity sometimes being as high as five pints. Degenerated epithelia and casts, entirely fatty and hyaline. Finally uræmic manifestations closed the scene. A post-mortem examination was obtained, and cirrhotic kidneys discovered. At no time could albumin be detected in the urine. The clinical picture of cirrhotic nephritis during the latter stages was perfect.

Case 6.—G. H., æt. 46, complaining of some general indefinite symptoms, led to my examining his urine. There was a well-marked albuminuria. Continued examinations demonstrated it to be intermittent, the period of its existence being perhaps two-thirds of the time. Upon one occasion, out of very many examinations, a narrow cast without adventitious contents was discovered. The genito-urinary passages were normal. After about two years the individual succumbed to an attack of cerebral hæmorrhage. I was so

fortunate as to make an autopsy. The hæmorrhage was from a well-marked sacculated pouch upon one of the branches of the left middle cerebral artery. The arteries were in general quite healthy. The kidneys were apparently normal in size, but the left one quite movable; capsules not thickened or adherent. In texture they seemed somewhat softened. The microscope showed light-walled, rather large vessels; indeed, with apparently large blood supply, the general framework of the organs seemed defective. Here and there there was slight intertubal hyperplasia. The tubular elements were rather large, and did not stain very well; had too much of a granular appearance, and the structural peculiarities of the renal epithelium did not come out well. There were no coagula within the tubes. It will be observed that the general indications are all in the direction of defective kidney development, from the loose attachment up to the large weak tubular epithelia, the latter having in slight degree the appearance and conditions found in acute nephritis, viz., slightly granular, indistinct structure, the seemingly large elements and increased blood supply. Observation of the kidneys of several persons dying from various diseases, during the course of which albumin occurred, have presented much the same appearances, but not the evidences of defective development.

Case 7.—I had the opportunity of examining, several years since, the kidneys of a man who had been under the care of a colleague for some time suffering from intermitting albuminuria. Evidences of Bright's disease of any other character had not been discovered. He was 43 years of age at death, and had been the subject of slight albuminuria for three years, so far as known. The kidneys seemed normal in their external conditions, but were rather soft. Their cut surfaces revealed nothing special. The left contained numerous calculi, all small and of the uric acid variety. The right only two small "gritty points." Upon enlargement the tubular epithelia were found slightly granular, here and there somewhat cloudy. Neither of these changes were pronounced, however. Looking over a large number of fields, indeed, sections, I discovered two casts in situ. Both were of clean, coagulable material and free from degenerate epithelium. While the epithelia impressed me as swollen, they were not sufficiently so to encroach upon the lumen of the tubes decidedly. Intertubular hyperplasia was clear at some points. If

there was any change in the blood supply it was diminished. The patient had suffered somewhat from rheumatism and frequently had sandy deposits in the urine.

Of cases of Bright's disease without albuminuria, at least during quite continued periods of observation or with an intermitted albuminuria, I could increase the number largely, but I have given sufficient to illustrate the point I would impress, *i.e.*, that Bright's disease does not always nor constantly, in a given case, present an albuminuria. From a study of the related cases and others in my own collection, as well as of the observations of others, I am impressed with several things:

First. Albuminuria must not be looked upon as necessary to the diagnosis of Bright's disease.

Second. Albuminuria often exists independently of any clinical or pathological evidence of nephritis or any condition of the genito-urinary tract which can account for it.

Third. Albuminuria, independent of Bright's disease, is sometimes associated with evidences of defective development of the kidneys, or rather an imperfect structural condition, which may, perhaps, be, in the main, acquired.

Fourth. The direction of the tubular and other changes is inflammatory.

Fifth. The absence in a majority of these cases of well-marked diathetic states, as lithæmia.

Hypotheses are valuable, as indicating lines of thought and work. I would propound: Does not the kidney, independently of recognized disease, vary in its structural integrity in different people?

As in some the cutaneous epithelia are imperfectly developed and an imperfect skin is the consequence, so in the kidney. Are not the epithelial glandular cells brought into existence with impaired nutritive activity, resulting in abnormal function-action? They stand guard but poorly and allow the most precious of the nutritive fluids to pass unchallenged. Do not the changes discovered in such kidneys suggest that all that is necessary to the development of Bright's disease is the application of the exciting causes of the inflammatory state?

May not the condition of the blood be closely related to persistent, so-called, physiological albuminuria?

While these few observations are of but little value in the forming of conclusions respecting the pathology of so interesting and important a condition, yet "every little helps," and I trust the results arrived at in these cases may lead to more careful study of similar ones.

CLINICAL CASES—WITH COMMENTS.

BY W. J. MARTIN, M.D., PITTSBURGH.

Mrs. A.B., residing in an adjoining county, wrote to me recently for medicine for the following condition: "Frequent, sudden jerks of the heart, followed by violent palpitation and oppression of the chest, with difficult breathing; nervousness." The condition had existed for some time, she said, and was steadily getting worse. She wrote to me for medicine because there was no Homœopathic physician in the place where she lived.

This leads me to digress for a moment here, and quote, as well as indorse, the following from the *Medical Era*, August, 1890: "There are too many physicians of the wrong kind in this country. With a population of sixty million people, the United States has one hundred thousand physicians. About ten thousand of these are Homœopathic physicians, the rest are, for the most part, Allopaths. The proportion could be reversed with great benefit to the people. There is need of more Homœopathic physicians. There is not a well-educated student, who graduates from any one of our thirteen colleges, who does not find that, somewhere, there is a community awaiting his coming, because the people want a Homœopathic physician. But there are enough of poor ones. The young man who enters the profession because he has failed in everything else he has undertaken, will find no room. Of well-educated, skillful and capable Homœopathic physicians, there will not be enough until their numbers equal those of the old school. And then, there will be room for more."

A short time ago, I saw a baby sick with broncho-pneumonia in a neighboring town, under the care of a Homœopathic physician

whose treatment, at the time of my visit, was ferrum phosphoricum and tartar emetic, in alternation, a dose every hour. He gave the ferrum phosphoricum because he had read or heard somewhere that it was good for pneumonia, and the tartar emetic he gave because he thought it the indicated remedy. More recently I was called to another neighboring town to see a case of typhoid fever under the care of the Homœopathic physician residing in the place. The patient, on the day of my visit, was getting bryonia 1 and baptisia *0* in water, a dose every hour alternately. He gave baptisia *0* because it is the great anti-typhoid remedy, and bryonia because the patient felt worse if she moved. (The indicated remedy in the case was arsenic, and on this she made a rapid and complete recovery.) Of this type of Homœopathic physicians there are enough; no more are needed. If our school of medicine is to survive, it must survive upon its merits. Its prosperity and growth will result only from the constant exemplification by its practitioners of the truth of the law of cure in which they profess to believe, and which we have adopted as the motto of our school.

But, to return to the woman with sudden jerks in the heart, followed by violent palpitation, oppression of the chest, and dyspnœa. By referring to Lilienthal's *Therapeutics*, third edition, we find under "Heart Diseases," that for jerks or shocks, agaricus, conium, graphites, lithium, manganese, phytolacca, or zincum, may be indicated. Turning to agaricus, we find the following symptoms, which correspond very closely to our case: "Sense of oppression in the cardiac region, as if the thorax was narrowed; painful shocks at the heart, with anxiety; patient hears the heart throb, and it lifts the hand lying on the chest; < in evening, with anxiety, and breaking out in cold sweat." This remedy also suited admirably the nervous disposition of the patient. I therefore sent her twelve powders of agaricus 200, a dose every four hours.

On July 30th she wrote, asking for more medicine of the same kind, saying: "I feel a great deal better, but my heart still jerks once in a while." I sent a package of blank powders, one to be taken every four hours. She has since written to tell me that she is now free from all the unpleasant sensations about the heart and quite well.

March 6, 1890.—Florence M., æt. seven years, was taken with

diphtheria. By the most careful examination I failed to get any peculiar or characteristic symptoms upon which to make a prescription. Both tonsils were equally swollen and equally covered by membrane, the uvula, nares and pharynx were not involved, and swallowing was not very painful. There was loss of appetite and general malaise. This is all there was in the case. The diagnosis was clear; it was a case of diphtheria. The diagnosis of *the* remedy was not clear to me, and I did that which I think now it is better not to do, viz., I prescribed for the name of the disease. I gave mercurius cyanatus 6, not because it was indicated, but because, not knowing what was indicated, and knowing that the case was diphtheria, I gave it as a good diphtheritic remedy.

In answer to the query, What better can we do sometimes under these circumstances? I think I would be right in saying, "Do nothing." Wait and watch the case until you feel sure you see the right remedy; then give it.

March 7.—Patient no worse. Throat looks no worse; perhaps a little better; but not enough to convince me that she was getting the right remedy. But, seeing nothing as yet indicated, the mercurius cyanatus 6 was continued.

March 8.—About same as yesterday. She appeared to be holding her own and that was all. Continued mercurius cyanatus 6.

March 9, 7 A.M.—Patient much worse, though she had slept well and rested during the night just passed, due probably to increasing prostration, as she was hardly able to sit up long enough to have the throat examined. The throat was much worse than it had been at any time before. It was a bad looking throat. All medicine was ordered to be stopped for four hours, at the end of which time I returned and re-examined the throat. It was worse than four hours previously. The case I considered a very serious one. I now proceeded, with the aid of Dr. William Jefferson Guernsey's *Card Repertory of Diphtheria,* to select the remedy indicated by all the symptoms at this time present. The symptoms, as I noted them at the time, were as follows:

1. Aggravation after sleep.
2. Blueness of throat.
3. Inflammation of uvula.
4. Membrane pearly-looking.

5. Membrane on uvula.
6. Œdematous swelling of uvula.
7. Voice hoarse.
8. Pain slight.

For the first of these symptoms the following remedies are indicated: Kali bichromicum, lac caninum, lachesis, mercurius jodatum rubrum.

For the second: Ailanthus, kali bichromicum, lachesis, mercurius cyanatus, phytolacca, sulphur.

For the third: Belladonna, kali bichromicum, mercurius, natrum muriaticum.

For the fourth: Kali bichromicum, sanguinaria.

For the fifth: Apis, mercurius jodatum flavum, kali bichromicum, nitric acid.

For the sixth: Apis, kali bichromicum.

For the seventh: Ammonium causticum, apis, kali bichromicum, lachesis.

For the eighth: Apis, baptisia, carbolic acid.

Now, by this process, we find that kali bichromicum is indicated for seven of these eight symptoms, apis is indicated in four, lachesis in three, and mercurius cyanatus in only one.

Accordingly, kali bichromicum, third trituration, was given, a small powder being administered every two hours. Nothing more was done; no swab, no gargle; only an occasional swallow of whisky for its chemical effect on the membrane. In six hours a change for the better was observable. The improvement continued without intermission day after day. The kali bichromicum was continued for four days, by which time the throat was nearly clear of membrane, and the uvula, which had been swollen to the thickness of my little finger, and an inch and a half long, was almost normal. The kali bichromicum was now discontinued, and one dose of sulphur 200 administered. No more medicine was given for a week, by which time she was well in every respect except hoarseness and cough, which, persisting, I gave phosphorus 12, a dose every four hours until better.

This case illustrates two modes of prescribing, an improper and a proper mode. The first prescription was improper; it was based upon the diagnosis; it was given for the name of the disease. The

second was a proper prescription ; it was based upon the symptoms present in this particular case, and peculiar to this particular case, and not common to all cases of the disease, which latter, however, were covered by the remedy also, and always must be in a truly Homœopathic prescription. It is not unfrequently the case that to make such a prescription it is necessary to write down the symptoms of the case, and with the aid of a repertory write down after each symptom all the remedies corresponding thereto, and, selecting the one corresponding to all the symptoms, or if there is none such, then the one corresponding to the most of the symptoms. Such a prescription will never, or hardly ever, fail ; whereas, those chosen on the strength of their reputation for being good for the disease, or being the favorite prescription of some eminent man, are as liable to fail as to succeed. It is with prescribers of this kind that so many adjuvant measures are required in order to pull a case through. The following is a "frightful example" of this style of prescription: "At the last meeting of the Round Table Club, Dr. B. recommended the use of cyanide of mercury, in the treatment of diphtheria, as follows: Cyanide of mercury, gr. $\frac{1}{3}$; Howay, oz. $\frac{1}{2}$; distilled water, oz. $4\frac{1}{2}$. Mix, and give a teaspoonful every one, two or three hours, according to the severity of the case. Gelsemium tincture, five drops in eight tablespoonfuls of water every half or one hour, is efficient in allaying the fever until the disease begins to subside. The tonsils and pharynx are swabbed every one, two or three hours, according to the amount of deposit, with $HgCl_2$, two grains to the pint of water. This solution to be kept in a glass jar free from contact with any metallic substance."

A paragraph is now devoted to describing the manner of swabbing the throat and pharynx with this powerful bichloride of mercury solution, and instructions how to make swabs, the article closing as follows: From the very first the use of stimulants is to be crowded. Milk punch is perhaps the best and most nourishing. If the glands are affected a compress is applied to the throat wet with the following solution : Liquor plumbi sub-acetatis, 3 drams to a pint of warm water. To hasten recovery, after convalescence is well established, chininum sulphuricum 2x is of service. A ventilated room and the patient warmly clad with a flannel gown, over this a tightly-

fitting jacket to protect the arms when exposed, complete the treatment.

And this is the treatment for all cases of diphtheria according to this article, which is taken from the college journal of a so-called Homœopathic college, and the author of the article is a professor in said so-called Homœopathic college. While on this subject I wish to reproduce a few remarks from an article in the editorial department of the *North American Journal of Homœopathy*, which have the true ring about them and are true to life.

"There are some misnamed Homœopaths who have never mastered the rudiments of Homœopathy, who know nothing of it as a science of therapeutics, and who could not by reason of limited mental power make a thoroughly Homœopathic, and therefore, thoroughly scientific, prescription, to save their deceptive reputations from merited ridicule. These are the gentry who strain their eyes to read in the journals that 'cicuta is good for convulsions,' that 'ferrum phosphoricum is good for bronchitis,' that 'berberis is good for pain in the back;' and who treasuring these vague and worse than useless hints, hasten to prescribe the drugs, regardless of the indications given by the symptomatology of the case. Such prescribers as these do not hesitate to use old-school prescriptions in preference to attempting to prescribe Homœopathically. Their method of treatment is not Homœopathic; it is the method of dull and senseless imitation. Men like those, masquerading as Homœopathic physicians, deserved to be stripped of their disguise and exposed to the contempt of the profession to which they wrongly claim to belong."

June 27, 1890. Richard T., occupation blacksmith, has been sick for ten weeks with some kind of a fever, under old-school treatment. Has been free from fever for some time now, yet does not get well; has no appetite; feels so weak and sweats so much; the least exertion exhausts and produces profuse pespiration; he has become hopeless and despairs of recovery. ℞. Psorinum 30, a dose every four hours.

July 2d. Mr. T. comes in smiling, "Feels a lot better," yet the appetite is poor and there is some pain in the back. Saccharum.

July 7th. Does not feel so well; has occipital headache, sitting up with the head resting on the back of a high-backed chair, no appetite; no thirst; tired feeling. Gelsemium 12, every two hours.

July 11th. Much better. Continue gelsemium 12, every two hours.

This was the last medicine he received, being strong and well enough to go to work when it was all taken. He has remained well since.

Psorinum, which was the efficient remedy in restoring this man to health, has been denounced in unmeasured terms by some high priests in our school as unfit for use, and has been relegated to the "annex" of our materia medica. I would be at a loss to know what to do in some cases without psorinum. As in the case just cited, its beneficial effects, in indicated cases, are prompt and clearly marked. I agree with the sentiment expressed by J. B. Bell, M.D., in his invaluable work on diarrhœa, etc., "Whether derived from purest gold or purest filth, our gratitude for its excellent services forbids us to inquire or care."

July 18, 1890. Baby F. vomits milk in large curds; after vomiting the child is very much exhausted. Æthusa 200, every two hours.

July 21st. The child does not vomit now, but has diarrhœa. The stools are profuse, green, slimy and *odorless.* It is an odd thing to meet with a case of infantile diarrhœa where the stools are odorless. Paullinia sorbilis is the odd remedy for this odd condition. I never had occasion before to use the remedy and prescribed it in this case with a feeling of curiosity as to the result. The twelfth potency was given. Three days later the child was reported better; the stools yellow, not too frequent and of natural odoriferousness.

DISCUSSION.

Dr. W. G. Dietz thanked Dr. Martin for his interesting paper. He said that one remedy of value in affections of the uvula had been omitted by the essayist, and that remedy was rhus tox. It is especially important when the uvula has the appearance of a little sac of water. There are three remedies of especial value in the treatment of diphtheria. They are lachesis, lycopodium and lac caninum. Lachesis is called for when the left side is involved, and lycopodium when the right. In these cases, when he is called in the beginning and finds the disease commencing on the left side, and there is infil-

tration of the surrounding tissues, and the symptoms are violent, he gives lachesis in a high potency. He usually gives three doses, and when the child is unusually sensitive only two. He could truly say that the drug rarely fails. He could say the same of lycopodium when the same condition prevails on the right side. A point to be remembered is that the lachesis patient complains of pain in the throat out of proportion to the objective symptoms. In cases of recovery from acute diseases, he would call attention to another remedy, in addition to psorinum as mentioned by Dr. Martin. That remedy was castoreum, and was first recommended by the late Dr. E. A. Farrington, where there is a lack of reaction after severe diseases and the patient has not vital force sufficient to react. Night sweats are profuse, and the patient does not know why.

OBSERVATIONS IN WHOOPING-COUGH.

BY C. VAN ARTSDALEN, M.D., ASHBOURNE.

Pertussis is a peculiarly specific, contagious, kind or form of irritation of the bronchi, with reflex spasm of the glottis and air tubes. Of the ætiological relations nothing really is known. It may occur in infancy as early as the third week, most frequently, however, between the second and seventh years, but older children are affected, and sometimes adults. The period of incubation is about ten days. I have known twenty-one days elapse before the cough began, after the contagious element had been conveyed from one child to another.

The usual preliminary symptoms observed in whooping-cough are sneezing, watery eyes, general bad feeling; slight, often sharp, cough; the patient very excitable; yet all these may be entirely absent. Later, the cough becomes spasmodic; the neck and veins of the neck and head may be swollen; there is staring of the eyes; the contents of the bladder and rectum may be involuntarily discharged. I have noticed frequently, on the approach of the paroxysm, that the child suddenly ceases to play, becomes restless and anxious, seizes some

firm object and holds fast until the attack has passed. During a paroxysm the child is bent forward.

The number of attacks occurring during twenty-four hours is variable. Many children have only six to ten spasms, while others as many as forty, all of the same severity. Crying will readily produce an attack. A paroxysm in one child will excite a sympathetic paroxysm in another similarly affected. During sleep a child will start up, pass through a paroxysm, lie down, and at once drop off to sleep again. While some are completely exhausted others are able to go on naturally, or as if nothing at all was the matter.

It is rare for whooping-cough to recur in the same individual. The average duration is about three months, but under Homœopathic treatment the duration is about three weeks, and seldom over six.

We may have as complications, bronchitis, pneumonia, croup, convulsions, vomiting and diarrhœa.

Measles, it is said, go hand in hand with whooping-cough, but I have never had such a complication.

I have noticed in two cases, children of weak constitution, the appearance of worms (ascarides) during the later part of the disease.

I firmly believe there is no disease for which so many specifics have been offered with such unsatisfactory results. Bromide of potassium, bromide of ammonium, extract of belladonna, hydrocyanic acid, valerian, morphia, together with any amount of patent remedies, have their advocates. Counter-irritation, blisters, followed by various applications equally as useless, have found admirers. Inhalations of carbolic acid, salicylate of soda, oil of turpentine, chloroform, benzine, etc., have each in their turn been received with favor by some.

The patient should enjoy, as much as possible, the fresh air, unless the weather be rough or very windy, or some complication be present. Then, the child should, by all means, be kept in the house, with light diet and without stimulants. The day as well as the night nursery should be of equal warmth and well ventilated.

After the paroxysms have almost ceased, when the child is much worn out by the struggle, a change would be advisable and useful.

I append the report of a few cases :

M. S——, æt. 8 months. There had been whooping-cough in the family for some time. This little fellow was away with the rest,

spending the summer in the mountains, where the disease first manifested itself, and by the time I saw him it was fully developed. He had swelling under both eyes; no thirst; expectoration copious; he could hardly get his breath when he attempted the least exertion; no appetite; cough worse from 4 to 8 P.M.; very dark urine, with a deposit like coffee-grounds. I gave helleborus niger, because of the last-named symptom, and the result was satisfactory in the extreme.

A young lady contracted whooping-cough just previous to her fourteenth birthday, and was not cured despite the learned Allopathic physician's treatment. She was so prostrated that she was obliged to take to her bed. The regularity of the paroxysms was very marked, and each attack was accompanied by jerking backward of the head, with general tremors. On account of these symptoms, cicuta was chosen, and this medicine relieved both the cough and the spasms of neck; but the patient is still very nervous.

Drosera rotundifolia cured a case in which there seemed to be no guiding symptom other than that the cough was worse at night after midnight.

Another case, of a six-year old boy, small for his age, who did not cough so hard, but would expectorate little round lumps tinged with blood, with oppression of chest. He seemed to gasp for breath, for which I prescribed laurocerasus, but with only partial relief. On making a closer examination, nausea was complained of, and I gave ipecacuanha, and was pleased to find my little friend soon well.

Following the last case was that of a middle-aged woman, unmarried, the nurse-girl of the boy. She contracted the cough from her charge, and when he would cough she would finish it up with a much harder spell and much more whooping. Her extreme weakness, together with such symptoms as flatulency; inability to retain the simplest food; cold feet and legs (for two days she was bedridden), led to the selection of carbo vegetabilis, and afterwards to ipecacuanha. In about four days she was able to go about the house and attend to her duties, and is now well.

THE HOMŒOPATHIC TREATMENT OF GOITRE.

BY CHARLES MOHR, M.D., PHILADELPHIA.

THE remedies that have proved useful in the treatment of goitre in the school of Hahnemann are: Aloes, ambra, ammonium, amyl nitrate, apis, arsenicum, aurum, badiaga, baryta carbonica, belladonna, bromine, calcarea fluorica, calcarea jodatum, calcarea ostrearum, carbo animalis, causticum, conium, digitalis, ferrum, fluoric acid, hepar sulphur, iodine, kali carbonicum, kali jodatum, lapis albus, lycopodium, lycopus virginicus, magnesia carbonica, mercurius, mercurius jodatum, mercurius binjodatum, natrum carbonicum, natrum muriaticum, natrum sulphuricum, nux vomica, petroleum, platinum, phosphorus, pulsatilla, silica, spongia, staphisagria, sulphur, testa ovi.

This list gives quite a large range in a disease having so few symptoms connected with a thyroid enlargement as ordinary goitre; but herein is included also the few remedies employed in the treatment of exophthalmic goitre, the symptoms of which are quite pronounced, and at times extremely distressing.

All these remedies have markedly relieved or cured goitre, proving that even in ordinary bronchocele, as well as in all other diseases, individualization should be the custom of the Homœopathist. I question, however, whether too much empirical prescribing is not done, for few works or journals mention more than iodine and spongia as applicable to this disease.

It is well known that few men comparatively suffer from goitrous affections, whereas women are very frequently victims, and in whom, it has been repeatedly observed, there are coincidently aberrations of the sexual functions.

I have been much interested in studying this phase of the subject, my attention having been called to it by some unique cases occurring in quite a number I have treated. One of the first cases of bronchocele to come to my notice was that of a girl, aged 17 years, who had had the disease several years, and had been variously treated for a whole year with external applications of iodine, which resulted in atrophying the mammæ, and presumably the ovaries, as for several

months there was complete cessation of the menses; but, instead of causing the thyroid enlargement to diminish, the gland kept on increasing in size. An inquiry into the early history of this girl's menstrual life revealed symptoms calling for calcarea ostrearum, which was followed by immediate improvement, and in ten months by complete recovery.

A sister of the above patient, at the age of 13, began to have goitre. Pulsatilla, indicated by the subjective symptoms and absence of menses, relieved the former promptly and brought on the monthly periods, and a complete *cure* of the bronchocele in eight months.

Another patient was a widow, aged 40. She had enlargement of the heart, with valvular lesions, and for many years had been a sufferer with exophthalmus and thyroid enlargement. This case I watched with much interest for several years. When the exophthalmus and thyroid enlargement became smaller, the uterus would enlarge in a corresponding ratio, and *vice versa*, and their alternation was repeatedly witnessed. At one time, when the goitre was quite small, and the exophthalmus almost gone, the abdomen was as large as a woman's at full term of gestation, and an examination at this time revealed an enormously hypertrophied uterus, which was rapidly diminished by free menorrhagia, and by a rapid increase again in the thyroid and exophthalmus. This woman died of general dropsy in 1884, after having been tapped twice, at a time when the uterus was large and the goitre small. The post-mortem revealed dropsy of all the closed cavities of the body; the right heart dilated; the left heart somewhat hypertrophied and dilated; the tricuspid and mitral valves incompetent, with slight calcareous deposits about the mitral and aortic orifices; the liver large and fatty; both kidneys large (white kidney); uterus uniformly hypertrophied, dense and hard, and as large as a fœtal head at term; right ovary cystic, left ovary atrophied. This patient had received, with marked benefit, aurum; that is to say, weeks of comparative comfort always followed its administration.

Another woman, aged 32, married, had exophthalmic goitre, and suffered with three successive abortions between the second and third months of pregnancy. In each instance the uterus was curetted owing to retained placenta, and her health was always bad.

The history of the abortions and nervous phenomena led to the prescription of kali carbonicum, which almost immediately improved the nervousness, cardiac palpitation and dyspnœa, and reduced the thyroid enlargement and exophthalmus. Subsequently, she became pregnant, and under the continued use of kali carbonicum she carried the fœtus to term, and was delivered of a healthy boy weighing eleven pounds, and to this day remains free from all trouble.

Did time permit I could give a detailed account of other similar cases, as well as of cases in which there was not so marked a co-relation between the thyroid gland and the glandular organs peculiar to woman. But, even in cases where there was no very marked connection, I have still found it necessary to adapt remedies occasionally to functional derangement of the sexual system, and my experience has taught me to give up the routine use of iodine and spongia, and to individualize each case, adapting the remedy to the sum of all the symptoms which were found to be most characteristic in the sexual sphere.

Discussion.

Dr. Trimble Pratt, in confirmation of Dr. Mohr's remarks regarding the association between thyroid enlargement and disease of the reproductive organs, cited one case in which, by treating large cystic tumors of both ovaries, the thyroid enlargement was rapidly removed, the enlargement of one ovary being entirely removed and the other being reduced two-thirds in size.

Dr. W. G. Dietz called attention to the well-known fact that extirpation of the thyroid gland is followed by a peculiar cachexia, which ends in death. We should always treat our patients, and not the names of their diseases. The true Homœopathic treatment will always be the most palliative.

STOOP AND ROUND SHOULDERS—THEIR RELATION TO CHEST EXPANSION AND PHTHISIS PULMONALIS.

BY E. R. SNADER, M.D., PHILADELPHIA.

It is a well-known clinical fact that the upper portion of the lung structure is first attacked by phthisis pulmonalis. In about 98 per cent. of cases the ravages of the disease are first noted at the summit of the chest. Apical solidification is considered to be one of the clinical laws of phthisis. Numberless theories have been evolved to account for the special predilection as to location evinced by the dread disease. The view most reasonable is that the summit of the lung is first and most frequently attacked by the germ agent or anatomical elements that induce the tissue changes incident to pulmonary phthisis, because the apices are the least used portions of the lung structure. Lack of functional activity is, therefore, considered to be the special predisposing factor in the selective affinity shown for the summit of the lungs by phthisis pulmonalis.

That the idea of the quiescence of the apices particularly, and sometimes of other portions of the pulmonary parenchyma, is held by many to be a cardinal causative condition for the production of pulmonary phthisis, is evidenced by the theories advanced by practical men to account for the lack of use, or limited use, of the apices and other parts of the lungs.

A view, apparently in opposition to the one under discussion, was promulgated by a German observer who had had a prolonged and extensive experience with phthisical patients in hospital practice. He stated that an overwhelming percentage of phthisical patients possessed abnormally large lungs. This opinion had been reached after years of careful study, research and observation, and he contended that numberless post-mortem examinations confirmed his view. Another important fact was noted in the dead-house observations: The large lungs were nearly always associated with small hearts. The fact of large lungs existing in phthisical patients is no evidence that large lungs are the special predisposing cause of the disease. The whole pathological picture must be viewed, not single

portions. I could accept the fact of extra large lungs in the phthisical dead, if it were proven indubitably, without embracing the theory drawn from the fact. The German observer's cases had large lungs and small hearts. Apparently, the little hearts were at the bottom of the trouble, not the big lungs. The hearts were too small for the lungs, not the lungs too large for the body; for, inferentially at least, it can be argued that the small hearts could not supply the large lungs with a sufficient amount of nutriment, and, consequently, the lungs were deficient in functional activity and a large area practically at rest; and it is *lung rest* that many regard as a specially powerful predisposing factor in the causation of consumption.

A distinguished doctor of this city goes further than the German observer. The latter thought phthisical lungs were large; the former believes that nearly all moderns have too much lung capacity. According to Dr. Mays's view, nearly the whole civilized race are large-lunged. These huge breathing-bags were bequeathed us by our aboriginal forefathers, whose pursuits demanded greater lung capacity than we need in our day. It can be inferred from the doctor's views that successive generations of wild life and heredity only increased the lung volume. Our large lungs, then, are bequeathed us by the breezy plains and sighing forests, moving monuments to the fleet-footed game our forefathers ran down and feasted upon. We have not lived long enough, are not far enough removed from ancestral influence, to have reduced our lung space to modern needs.

I need not devote much time to refute this view. It seems to me impossible and illogical to dogmatically fix the limit of the proper size of the lungs. To delimit nature is a difficult task, and nature has apparently performed her work well by providing sufficient lung capacity for emergencies. Man can live at an extremely high altitude and use every fraction of an inch of his lung space. If the pulmonary parenchyma were simply sufficient for ordinary needs, an unusual demand for air would result in death, and every pneumonia would kill, and even a trifling bronchitis would end fatally. Running, exertion or laborious pursuits would be impossible. To say that the lungs of man are too large is not sufficient. So long as their proper size is not provided for, it seems wise to accept our large lungs, if we really have them, as a gift of beneficent nature. It is better to accept

nature's make-up than a theory. The conclusions drawn from the large-lung theory are that many of the cells are not used, and that the rest thus induced predisposes to phthisis pulmonalis.

I certainly believe that lack of functional activity in the lungs predisposes those organs to disease, but I cannot see how a theory of unnecessarily large lungs helps greatly toward a solution of the problem of how pulmonary quiescence is really caused. It is reasonable to suppose that undue lung rest predisposes to lung disease, for it is a fact well known that if organs are unused, or only partially used, their functional activity is lessened, and if their functional activity is lessened they are supplied with less nutriment, and if they are supplied with less nutriment they fall below physiological par, and if they fall below physiological par the organs are more susceptible to disease and disease influences.

I wish to consider one potent cause of lung rest—stoop or round shoulders. Any one who is stoop- or round-shouldered is not in a normal position for using the lungs freely and readily. The weight of the shoulders, overhanging the thorax, acts as a mechanical bar to the easy expansion of the upper portion of the chest. This bad bodily habit ultimately leads to disuse of many of the muscles of respiration and of the upper lung structure, and in consequence the summit of the chest remains nearly, if not quite, quiescent.

Stoop or round shoulders are, I know, nearly universal, and phthisis pulmonalis is not. Can it then be argued that there exists any sort of relationship between a bad bodily habit and the dire disease, consumption? To my mind there are a number of very good reasons for believing that stoop or round shoulders are a strong predisposing cause of phthisis pulmonalis.

First.—The summit of the lungs are first and most frequently attacked by phthisis. Rest is a causative factor. At the summit of the chest is the quietest part of the lung structure. The causative agent of phthisis seeks the tissues least able to resist disease.

Second.—The frequent presence, at the beginning of a physical examination, of adventitious sounds at the summit of the chest, the sounds disappearing after a few deep respirations, the respiratory murmur disclosing no abnormalities. These sounds, it appears reasonable to suppose, have precisely the same origin and mechanism as those frequently found when we auscultate a patient who has been

long recumbent, as in typhoid fever. The cause of the râles in both instances is lung rest and the agglutination of a number of air-vesicles.

Third.—The greater the disease existing at the apex the greater the abeyance of movement. If disease lessens functional activity, lessened functional activity ought to predispose to the disease that lessens it.

Fourth.—The almost universal immunity from phthisis among emphysematous patients. The dilated condition of the air-cells in the latter disease prevents or militates against solidification. Disease in emphysema keeps the air-cells open, and healthy activity of the apices keeps the vesicular structures distended, the blood circulating freely, the tissues properly nourished; and, therefore, active apices, from health or disease, tend to prevent phthisis pulmonalis. (A French doctor attempted to produce emphysema in order to save his consumptive patients.)

Fifth.—The effect of respiratory gymnastics upon a diminished summit expansion due to solidification. The physical signs showing solidification of the apex are considerably and often greatly modified for the better by exercise leading to a re-establishment of proper breathing at the summit. The general symptoms, as well as the physical signs, often show such an improvement after the inauguration of correct respiration that it leads to the opinion that had the vital capacity not been seriously diminished (and many air-cells permitted to go unused) by such bodily habits, the disease would have not been able to obtain a foothold, or, if a foothold had been gained, it would have not been possible to hold its first vantage.

Sixth.—Even where no actual lung lesion is found many cases of anæmia and other diseases are sometimes quickly restored to health by gymnastic exercises directed *alone* to securing a proper expansion of the superior portion of the chest. If amelioration of general health follows increased summit expansion, it seems reasonable to suppose that diminished summit expansion is quite capable of giving rise to a systemic condition below par; in other words, would predispose to disease, and particularly to a disease that by preference attacks the lung apices.

Seventh.—The abnormal conditions of the bloodvessels in the apices in the stoop-shouldered predispose to disease. When the air-

cells are only partially filled with air the vessels supplying the cells are lessened in their area of distribution. The air-cells below, actively carrying on the function of hæmatosis, press upon the cells of the quiescent summit and further diminish the amount of air in the vesicles and crowd and compress the bloodvessels. Now what happens? If the heart be strong the obstruction offered by the crowded vessels is overcome. In time, however, the vessels become relaxed, and the returning blood in the veins becomes more or less stagnant, offering still further obstruction to the circulation, and a slight œdema occurs. The small amount of air in the vesicles is further diminished in quantity by the swollen vessels, narrowing the lumen of the cells, and finally the walls of the air-cells, soggy with moisture exuded from the vessels and, almost, if not entirely, airless, collapse and fall together. Every respiratory movement transmitted from the active cells below and about the quiescent vesicles causes attrition of the approximated cell-walls, irritates the epithelial lining, causes a proliferation of the epithelial cells, and an apical catarrh, a catarrhal pneumonia, is inaugurated. Now if the distended vessels, from special exertion or from sheer weakness and lack of tone from long continued congestion, exude blood, the fluid extravasates through the unused tissues, increasing the solidification, and leading to caseous degeneration of the results of the hæmorrhage and of the intra-vesicular inflammation. Tubercle bacilli may be present or not. That a considerable degree of moisture (it may be only a slight increase over the normal amount) is present at the summit of the chest when the apices are not freely used I am quite confident. I base my belief in the existence of this physical condition, under the circumstances I mention, upon the fact of the frequent discovery of extremely fine, moist and dry sounds, at the apices at the beginning of many examinations, in which no actual named lung lesions are discoverable.

Eighth.—The discovery during the course of systematic examinations of the chest of considerable areas of collapsed lung tissue at the thoracic summit. I have determined the solidification incident to the collapse to be neither tubercular nor catarrhal pneumonic by the speedy restoration of the normal percussion note and normal respiratory murmur following the carrying out of systematic respiratory gymnastics. These cases presented none of the symptoms of

phthisis, and some not even the clinical phenomena of an ordinary bronchitis. I have known the respiratory murmur to return to its normal characters as to pitch and quality, after having presented all the evidences of solidification, and the chest expansion to be greatly augmented, after only two weeks' exercise. The respiratory murmur assumed its normal characters and the percussion note its vesicular quality when the stoop-shoulders had been corrected and deep breathing had been practiced. Had such cases been examined by me in the earlier years of my experience in physical diagnosis I would have diagnosed either fibrosis or non-progressive phthisis. It appears to me that the fact of the occurrence of these areas of collapse, and a diminution in the expansion at the summit, demonstrates forcibly that stoop shoulders are capable of inaugurating all the phenomena I have indicated.

Ninth.—It is a fair assumption that some of the benefit derived in the treatment of phthisis by compound oxygen and other inhalations is due to the increased expansion of the air cells, and not all to the medicaments employed. Physicians who employ inhalations take special pride in mentioning the increase in the vital capacity as an evidence of the efficacy of their treatment, when that particular part of the improvement is, to my mind, really due to the practice of deep breathing. I do not wish to be dogmatic about the efficiency or inefficacy of oxygen or other inhalants ; I simply wish to say that my results obtained from deep breathing alone are more than favorably comparable with those obtained by the use of inhalants. Hence, I believe I am justified in the assumption that it is largely, if not altogether, due to the increased lung activity induced by the use of inhalants that the improvement so frequently noted is due.

I believe, then, that lung inactivity is a predisposing cause of consumption, and that the special localization of phthisis pulmonalis at the lung apices finds its most reasonable explanation in the fact that the naturally diminished movements of the summit are morbidly intensified and rendered powerful for evil by faulty positions of the shoulders.

Let me recapitulate my reasons for this belief very briefly.

1. The natural and acquired quiescence of the apices.

2. The presence (frequently) of adventitious sounds at the summit, the respiratory murmur maintaining its normal characters.

3. The abeyance of chest movements when the upper part of the lungs are only slightly used.

4. The immunity from phthisis shown by emphysematous patients.

5. The apparent lessening of the area of lung solidifications after the inauguration of upper chest respiratory gymnastics.

6. The effect of the correction of stoop or round shoulders upon the general health.

7. The turgid condition of the bloodvessels at the apices induced by the enforced quietude of cells, by reason of the limited expansion due to stoop shoulders.

8. The presence of areas of collapsed lung tissue at the summit in cases of pronounced stoop shoulders.

9. The increased vital capacity following forced breathing while undergoing treatment with inhalations.

It seems to me that these several reasons furnish sufficient ground for believing, not only that the quiescence of the summit is the cause of the special affinity of phthisis for the apices of the lungs, but also that stoop shoulders are a strong predisposing factor for the development of that dread disorder.

Let me answer a few objections that may possibly be urged against the views I have announced. Is not the universality of stoop and round shoulders and the relative infrequency of phthisis, an argument against the view that stoop shoulders are a predisposing cause of phthisis pulmonalis? I think not. Consumption requires for its development at least two, and possibly three, factors, in operation at the same time: First, a special soil; and second, the tubercle bacillus, or irritability of epithelial elements, and lung quiescence. Unused apices furnish a special soil for the development of either catarrhal pneumonia or tuberculosis, or both, the exact disease being dependent upon special circumstances. Another point to be taken into consideration is, that although most persons are stoop or round shouldered, their apices are not always quiet. Their occupations, exercise, or occasional extra demands for more air than is used in ordinary respiration, does not permit the summit to remain continuously inactive, and hence the vessel torsion, the œdema, and the collapse are occasionally relieved.

Have I ever found lung consolidation incident to phthisis in indi-

viduals whose apical expansion was good? Yes. I recall, without referring to records, three instances, all very muscular men (two were athletes), in which the chest expansion at the summit and elsewhere was great. In all three cases I found positive signs of lung consolidation. In one, a machinist, who rejoiced in his strength, and daily lifted heavy burdens, I found the solidification at the outer portion of the left apex, about an inch below the clavicle. He used the right arm much more extensively than the left, and there was, therefore, relative quiescence of the left summit. In the other two the solidification was found in the central portions of the chest, a little below the bifurcation of the primary bronchi. The position of the solidification in these two instances (I excluded syphilis) led to the inference that the lung-tissue was involved in this particular situation in consequence of direct inhalation of infecting agents through the bronchial tubes. Whether the extremely good expansion in these three cases was due to large lungs, or simply to well-developed muscles, was not determinable by the methods of physical exploration. Their chests were not huge, but simply graceful in their perfect symmetry.

Have I ever found phthisical solidifications at the base of the lungs? Yes. I recall two cases, both in females, who laced tightly, and who breathed freely with the upper portion of their lungs.

Does not the fact that women, who breathe with the upper portion of the chest, have phthisis quite as frequently as men, invalidate the idea that quiescence of the apices is a predisposing cause of consumption? I do not think so. If supracostal breathing be characteristic of women, as is believed and taught by physiologists, it is a clinical fact, according to my individual observation, that, during ordinary respiration the supracostal method is seldom used, and therefore there is induced a relative quiescence of the lung apices; indeed, if the physiologists be right, the summit abeyance of movement is greater relatively in women than in men. If, on the other hand, women should breathe by the abdominal method, as is contended by some authorities, there still exists a relative quiescence of the summit, despite the fact that women (as I have repeatedly noted) more readily assume the supracostal style of respiration than men, because of women's smaller lungs, weaker muscular system, sedentary habits, and confinement in-doors. I am not endeavoring to prove that a

quiet summit is the cause of all cases of phthisis. I am simply trying to show that stoop and round shoulders are a strong, a prominent, predisposing factor for the inauguration of a chain of changes in the apices of the lung structure that result in the symptomatic phenomena and the physical evidences of the disease we know clinically as consumption.

The considerations I have recorded in this paper lead me to believe that lung quiescence is a predisposing factor for the production of phthisis; that apical quietude determines the special primary localizations of that disease; that any measures of prophylaxis against or treatment of consumption that does not contemplate the restoration to functional activity of little used or unused air-cells is futile, unscientific, and purely palliative; that as a prophylactic against general ill health it is our duty to instruct our patients how to overcome this bodily deformity.

How can stoop or round shoulders be overcome? There are several methods of exercise by which it can be accomplished. If it be remembered that our principal object is not simply to overcome the deformity for the deformity's sake, but because it acts as a barrier to breathing freely with the apices, it will be seen that it will be necessary to practice deep breathing in connection with any movements designed to correct the faulty body habit. There are three methods by which the air vesicles can be distended. First, by raising the shoulders, bringing into play the extrinsic muscles of respiration; second, by movements of the abdominal muscles and diaphragm, filling the air-cells apparently from below upwards; third, by filling the air-cells gradually and pushing the lung structures out against the chest-walls. All three methods are of value. But, at first, it is my endeavor to secure active apices. I advise my patients, the first thing in the morning, when they have upon them only their night robes, to stand as nearly erect as they can, raise their arms vertically above the head, the muscles being slightly tensioned, and then allow the outstretched arms to fall slowly, almost by their own weight, keeping them inclined backward. This motion is repeated several times at first, and the time for the exercise is gradually lengthened. Later I have the patient inspire while allowing the arms to fall.

Another movement is the use of a pole about a foot longer than

the lateral reach of the two arms outstretched, and, grasping the pole in front of the body, with the arms stretched nearly to their limit, bringing the pole over the head, and letting the arms and pole fall gradually until the pole strikes against the back. This movement is also, after skill is shown in its performance, accompanied by forced inhalation and exhalation.

Causing the arms, the muscles, being somewhat tense, to describe a complete circle, from behind forward and *vice-versa*, with the outstretched arms a little inclined above the level of the shoulder, is a procedure of value; as is also a side movement of each arm describing a segment of a circle.

Raising the shoulders and rotating the head of the humerus in the socket, and making the backward motion pronounced, is a good movement.

Swaying the body from side to side, the arms hanging limp and swinging from the body only, tends to develop the abdominal and intercostal muscles, aids free diaphragmatic movements, and gives greater mobility to the shoulders.

All these movements, and many more, are applicable for the purpose of correcting the special deformity under consideration. To all are added breathing movements. All are modified to suit individual needs. I have not, in any case, employed violent exercise. I do not care to have weights, even light ones, used while the movements are carried out.

I regulate the amount of exercise altogether by the fatigue induced. I always stop short of pronounced fatigue. Many patients will complain of dizziness during the exercise, and will desist on that account. I do not stop the exercise for this symptom (due probably to alterations in the cerebral circulation), but lessen the number of movements, soon gradually increasing them and finally passing the point where vertigo was at first produced.

I have my patient practice deep breathing, particularly of the upper portion of the chest, sometimes without conjoining it with exercise.

Where the stoop shoulders are pronounced, I forbid high pillows. I recommend very strongly indeed, in some instances, the taking of lessons in singing, flute and cornet playing. Some cases require a

long time before an improvement is observable, and this is particularly noticeable in persons over forty years of age.

I also enjoin voluntary anterior, posterior and lateral movements of the abdominal muscles. I insist that women shall wear loose corsets, and in some who have apparently an insuperable objection to anything like voluntary exercise, I have read as many words as they can with one breath. They occasionally become interested in the performance, and involuntarily straighten up and take deep breaths. I then have a text from which I can preach to advantage.

The movements I have here given, or others that are specially adapted to special cases, will in most cases correct stoop or round shoulders, if persisted in. Many of the Swedish movements are specially adapted to aid in the cure of this deformity.

DISCUSSION.

Dr. Chas. Mohr believed with the author that we should endeavor to correct these deformities by proper exercise. When we find such deformities with flattening of the chest, and the apice sof the lungs not performing their functions, if we institute proper breathing exercise, we will do much toward lessening the number of phthisical patients. He had frequently seen in his own practice patients with undoubtedly phthisical habit, many of the members of whose families had succumbed to lung disease, improve wonderfully in their vital capacity and general well-being when they were instructed to expand the lungs forcibly for two, three or five times daily. When the patient performs breathing exercise, the speaker said that he generally recommended them to do it while walking or going up stairs. In cases in which two forcible respirations in succession tire the patient, he recommended them to take but one the first day, the next day two, and so on until the maximum quantity is reached. In other words, he used judgment. He believed with the essayist that many of the so-called cures following the oxygen treatment are really nothing more than the result of the exercise of the chest functions necessitated by this plan of treatment rather than to any specific effects of the oxygen itself. Still he was free to admit that oxygen was a useful adjunct. It is very important that the patient be taught to make forced exhalation. He directed his patients to keep the lips closed and take all the air in through the nos-

trils and expel the air from the chest until they have used all their muscular effort and the chest walls have sunken to the greatest possible extent.

Dr. Aug. Korndœrfer said that he could confirm the experience of Dr. Snader and the last speaker from his own personal experience. Coming himself from a phthisical family he apprehended that he might have some trouble. So during his college life he began to take these deep breathing exercises. The late Dr. Jackson, somewhere in the '40's, recommended to Dr. Williamson, whose daughter was then supposed to be dying with phthisis, that she go South and use deep breathing exercise. He suggested a very simple method for taking these exercises. Two or three times daily, fasting, or just before meals, the patient should take one deep inhalation, first having exhaled as deeply as possible, filling the lungs well through the nostrils and blowing the air slowly through a quill. This method has the advantage of retaining the air in the lungs and at the same time necessitates considerable exertion from below to completely empty the chest. Thus the air is forced into the minutest air cells. This practice Dr. Korndœrfer had followed himself, and he thought that he bore very good evidence of the good effects that would follow its use. The chest measurement will sometimes increase one inch in less than three months by this treatment. There is a caution to go with this treatment. The patient should not imagine because one breath does good, two will do more good. On one or more occasions he had had patients who have overexerted themselves with this exercise, and had had hæmorrhages in consequence.

INORDINATE PAROXYSMAL PALPITATION OF THE HEART AND ITS TREATMENT.

BY W. W. VAN BAUN, M.D., PHILADELPHIA.

Occasionally we come in contact with and are perplexed concerning patients with paroxysmal hurry of the heart who present no permanent recognizable disease of that organ, though they may show evidence of temporary dilatation and murmur. This condi-

tion differs from the group of clinical cases with persistent cardiac acceleration, known as tachycardia. The attention of the medical world has recently been invited to a consideration of this class of cases by Drs. Bristowe, Broadbent and Samuel West. The characteristic symptoms of the condition are found in individuals, apparently healthy, between the age of thirty and forty, who are suddenly seized with an attack of extremely rapid cardiac action. During the paroxysm the beating of the heart may range from two to three hundred pulsations per minute. Palpitation may be evident to the patient, but, as a rule, they are not conscious of the cardiac flurry. Sometimes præcordial pain accompanies the furious action. The attacks come on in paroxysms, without warning or assignable cause, and may last a few minutes or hours, or even days before the normal pulse rate is re-established. The rapid pulsation may occasionally alternate with great infrequency of the pulse. Dr. Bristowe records a case where two hundred beats gave place to thirty-four in a few days. There will probably be no other symptoms, and, excepting during the paroxysms, the patients will be in no way incapacitated, and will be capable of attending to the usual occupation, be it either physical labor or mental strain. If the attacks should recur with great frequency, or if they be associated with severe pain and pronounced palpitation, then the patient is placed at a disadvantage and is practically unable to attend to work. The attacks consist of a number of paroxysms at greater or less intervals, the usual course being for them to return with an increasing severity and with diminishing intervals of freedom, although there may be no return for years. Some patients will present signs of organic lesion ; the majority on record, however, give no evidence of organic diseases. During an attack the apex may be displaced, with increased cardiac dulness due to dilatation, while cardiac murmurs of varying intensity may be present. All the physical signs may pass away with the attack and no cardiac lesion be left behind. Some of the cases recover, while others succumb suddenly to cardiac syncope, or gradually of cardiac failure, where there is no evidence of valvular lesion. This latter condition proves without doubt that cardiac lesion cannot be altogether excluded. The real nature of the affection is still the subject of speculation. Dr. Bristowe regards the condition as purely functional, and in those cases where heart

disease was present, he considers the cardiac lesion to be secondary to the attacks of palpitation. Dr. West is of the opinion that cases of paroxysmal hurry of the heart are not due to functional disturbance alone, but that the weight of evidence is strongly in favor of some structural, though presumably temporary, change in the muscular tissue, the valvular tissue not being involved. It has been observed that a gradual failure of the heart is apt to supervene in these cases. Where this condition is present the prognosis is grave respecting both the return of the paroxysms and the ultimate outcome. Dr. A. Symons Eccles has noticed the coincidence of extreme rapidity of the heart's action with floating kidney in four cases, dilatation of the stomach in two cases, and in profuse menorrhagia at the menopause, in two cases. These cases have induced him, in default of pathological evidence to the contrary, to regard prolonged irritation of the abdominal sympathetic, either continuous or intermittent, as a probable cause of paroxysmal tachycardia, resulting from reflex inhibition of the vagus, or stimulation or fatigue of the vagus centre, or from the reference of irritation of the sympathetic periphery in the abdomen to the cardiac accelerator fibres of the sympathetic, in the same way as might frequently be noticed in regard to cerebro-spinal nerves of sensation. With the knowledge at hand it is impossible to prove any of these conclusions, yet as many of the recorded cases show antecedents, such as rheumatism, syphilis, together with undue strain as a not uncommon exciting cause, we are naturally led to the belief that the opinion of Dr. West is worthy of great consideration.

Case 1.—*Sudden collapse*: *pulse* 200–250; *with no assignable cause*; *no murmur*; *irregular rhythm.* History: Indefinite rheumatic; domestic trouble; previous attack, one year ago; recovery. Mrs. A. H., aged thirty-five; married; one child, twelve years old. A frail woman, five feet two inches in height, weighing about 105 pounds. When first seen the patient was almost in a state of collapse, face pallid and distressed. Pulse difficult to count, ranging over 240 beats per minute, rhythm irregular. There was no evidence of cardiac lesion and no symptoms, excepting a sense of impending death. Palpitation was not complained of even on asking direct questions. The patient was immediately put to bed, and as there were practically no symptoms, excepting the objective appear-

ance of a weak, poorly nourished, anæmic woman, with an irregular excessively acting heart and pulse, chininum arsenicosum 2x was given in one-grain doses hourly. The next morning the patient stated that, while she had passed an uncomfortable night, she felt stronger and better; she had found that an occasional deep inspiration would produce a grateful sense of relief. There were no symptoms, excepting an indefinable distress which prevented her resting, consequently she had had but little sleep. The pulse was beating 200 to the minute. On examination, the apex was found depressed and situated half an inch to the left of the nipple line, just above the upper border of the sixth rib. The cardiac dulness did not reach upward, but it did extend slightly to the right of the sternum, an impulse being felt at this situation indicating dilatation. There was no evidence of valvular disease. Change of position did not seem to affect either the frequency or the force of the pulse. The remedy was continued, with a nutritious liquid diet; coffee and tea being forbidden; the patient being kept at rest in bed. The next morning the improvement was quite marked. The character of the pulse had greatly improved, and averaged 130 per minute. Treatment continued. The next day the patient was up attending to her customary household duties, the pulse beating 90 and the respirations numbering 20. The respirations had never run over 34 to the minute during the entire attack. The urine was normal in quantity, light yellow in color, reaction acid, specific gravity 1020, and it gave negative results to albumen and sugar tests. There was no direct history of rheumatism. For years the patient had been subject to chronic pharyngitis with recurrent attacks of severe laryngitis. She informed me that one year ago she had been troubled with a beating, or throbbing, in the region of the umbilicus, as if something alive was inside of her. It alarmed her greatly. Continuing for some time, she took some proprietary medicine for tape-worm. The worm, however, did not appear, and the throbbing gradually passed away not to again return. Two weeks after the present attack the patient was as well as usual, the pulse being much stronger and beating regularly at 80 per minute. This attack lasted nearly four days. Five weeks after the first attack, without known cause, while sitting in a rocking-chair, she had a second paroxysm similar in nature to the first; the pulse beating from 200 to 250 per minute. There

was this difference, however; the patient did not yield to treatment. Chininum arsenicosum, croton tiglium, hydrocyanic acid, strychnine and tabacum were all given without result. At times her hands and face would be bathed in a cold sweat. As the pulse tension was moderately high glonoin was used; it failed to produce the desired amelioration of the symptoms and had no influence on the pulse. The pulse continued beating steadily at over 200 per minute for more than a week. On the eighth and ninth day, digitalis tincture, in thirty-drop doses, every four hours, improved the character of the pulse, but did not lessen its frequency. On the tenth day strophanthus was given in five-drop doses every four hours. On the afternoon of the eleventh day the pulse dropped to 90 beats per minute. The patient regained her customary strength and activity in a remarkably short time. During this prolonged paroxysm she never once complained of dyspnœa. She was very weak, and a constant sense of impending death kept her in a state of mental anguish; there were no other symptoms. During the next six months at intervals varying from three to six weeks, the patient would be seized with attacks of this extraordinary palpitation, although none of the subsequent paroxysms lasted for more than three days at any one time, and frequently they would pass away in six or eight hours; they gradually lessened in severity, the pulse falling from over 200 to 130 per minute. During the interval between the attacks the patient's health was as good as usual, the pulse beating from 75 to 85 per minute. The latter attacks all seemed to be controlled by strophanthus.

It has now been seven months since the patient has had an attack, and she considers herself a well woman—an opinion which I cannot endorse. It is not probable that her attacks were due merely to functional disturbances. In this case the attacks came on suddenly without known cause. The second paroxysm failed to yield to treatment, and gradually wore itself out. The use of strophanthus may have hastened the termination of this paroxysm, as the subsequent history shows that all the other paroxysms were shorter in duration and less violent. The last attack continued about eight hours and caused comparatively little inconvenience.

Case 2.—*Sudden faintness; anxiety; pulse* 240; *threatened collapse; cardiac dilatation; no dyspnœa; relieved by glonoin and*

tabacum; *recurrent attacks*; *rapid restoration between attacks to general health*; *recovery.*

Mr. H. K., aged 30, hardware clerk. He had been feeling as well as usual, when on stooping over to lift a package from the floor he was taken suddenly ill, with a sensation of nausea, extreme prostration, and a distressed feeling in his chest. He was given a drink of whisky, sent home, and put to bed. When I saw him his pulse, while soft and weak, was beating regularly and distinctly 240 pulsations per minute. He seemed to be bordering on a state of collapse. His only complaint was a sense of faintness. This was associated with considerable anxiety and mental excitement. There were no indications of cardiac lesion, there being neither murmur or friction sound. The apex was to the left of the nipple in the fifth interspace, diffused two finger tips in breadth. In this case I was fearful lest the patient would die of a heart paralyzed in diastole. One-drop doses of the third centesimal alcoholic solution of glonoin every three hours, in ten hours produced an extremely gratifying result. The cardiac action was slowed and the danger averted. For the next six days the patient was anæmic and bathed in perspiration. While he remained in bed he seemed to be perfectly well. The instant he would leave his couch the pulse would jump from an even hundred up to two hundred and over. This was associated with a sickening anguish which he could not express. On the third day there was no apparent change for the better; the symptoms indicated a degree of chest oppression without pain. The patient complained constantly that a great misfortune had happened to him, the nature of which he was not able to explain. His pulse was 150, and his skin was bathed in perspiration. He was placed on tarantula 30. On the seventh day, to my surprise, the patient, excepting his weakness, became suddenly as well as ever, the pulse being normal. Three days later the signs of dilatation having passed away he returned to his business. Eight weeks after his first paroxysm he had a second attack. In addition to the peculiar sick distress and pallor he stated that he had been annoyed with an alternating diarrhœa and constipation, an occasional sense of palpitation, muscæ volitantes, tinnitus aurium, and at times a dry cough.

The pulse when felt was beating 200 to the minute, and at this time there was no complaint of palpitation. The patient not using to-

bacco, he was given tabacum 30th, and the attack terminated in three days. During the next four or five months, ending April, 1889, since which time I have not seen him, the patient had a number of paroxysms of excessive heart-hurry, the severity of the paroxysms gradually ceasing and the free interval lengthening. Tabacum 30th always seemed to give him relief. Careful physical examination showed the man to be to all intent and purpose organically sound. Yet from some hidden cause he suffered from paroxysms of the most rapid heart beating, lasting at times from three to twenty hours, that I had ever seen. After the cessation of the attack the rapid return to usual health was astonishing. Another strange factor in this case was that he never complained of a sense of palpitation during a paroxysm. General treatment: Naturally in desperate cases with threatening cardiac paralysis we turn to stimulants like alcohol and ammonia, or to the more rapidly acting heart tonics, amyl nitrite or glonoin; the latter while not quite so prompt in action as amyl nitrite is much the safer drug. In the first of the two cases related at length glonoin proved to be of absolutely no value, while in the second case it produced a condition that was less dangerous than before it was given, but its continued use failed to produce curative results. In the first instance, after using many remedies, strophanthus proved effectual, and in the latter case tabacum 30th produced results that could not help but be gratifying. My experience being too limited to mark out a clear-cut line of treatment, I look for good results from the group of similarly acting remedies such as amygdalæ amaræ aquæ, amyl nitrate, atropinum, chininum arsenicosum and sulphuricum, glonoin, jaborandi, kali nitricum, naja tripudians, pilocarpinum, strychninum, tabacum, thea, and, lastly, digitalis and strophanthus. The patient is to be placed on his right side in as near a horizontal position as possible. Huchard recommends a spray of bichloride of methyl to the præcordium, the back of the neck or to the chest. When the cardiac weakness is very marked and syncope is present direct cardiac stimulation is necessary, such as has been suggested above or by means of hypodermic injections of ether or caffeine, together with inhalations of amyl nitrite. During the interval between attacks coffee, tea, alcohol in any shape and tobacco are to be strictly forbidden.

DISCUSSION.

Dr. E. H. Van Deusen said that two cases such as the essayist had described had come under his care recently. One case was that of a lady, aged thirty-two, four months gone in pregnancy, had a severe attack. She seemed to be suffering greatly, and thought that she would die. Her face wore an anxious expression, and she complained of a sensation as of a thrill in the neighborhood of the heart. She said that she had suffered from palpitation before, but that she had never had an attack as severe as this one. He gave her aconite because of this anxiety, and because when she was in the street, she feared that she would be run over, and she feared that she might die. He also applied cold over the heart. In a very short time, a minute or two, the heart's action became slow, when the ice was removed. He had examined her heart since and failed to find any evidence of disease. She has had no recurrence to date, and her pregnancy has progressed favorably. The other case was that of a boy aged fifteen. The attacks would come on him while in the street without any warning whatever. They would consist of a sensation as of a thrill over the heart. His ordinary pulse rate was 80 or 90. During the attacks of palpitation the pulse was uncountable. He also had at irregular intervals sharp sticking pains, for which he was given spigelia, which seemed to control the palpitation also. He also had fainting spells occasionally, especially when in a close, warm room.

Dr. W. G. Dietz reported the case of a friend whose heartbeat was so fast that he could not count it. The paroxysm came on him suddenly. The speaker said that he was far more frightened than the patient, who did not seem to have any anxiety whatever. He could not recall the remedy that he prescribed. The patient had had these attacks off and on for years.

POST-FEBRILE, DIPHTHERITIC AND INFANTILE PARALYSES, WITH AN ILLUSTRATIVE CASE OF EACH.

BY E. C. PARSONS, M.D., MEADVILLE.

It is a source of no little annoyance and chagrin to the conscientious practitioner to find (after weeks of careful treatment of a case of typhoid fever, diphtheria, scarlet fever or other exanthemata, when fever had given place to hope and the symptoms had given promise of an early restoration to health), that his patient, notwithstanding the previously favorable omens, has relapsed into a condition of utter helplessness.

The friends of the patient, if not previously warned of the possibility of such an exigency, are liable to entertain the conviction, if they do not openly reflect upon the medical attendant, that had measures somewhat different been adopted perhaps it might have been otherwise.

"To be forewarned is to be forearmed." The object of this paper therefore, is to consider how we may best anticipate such a result and how best to treat it should it obtain.

Paralysis has been defined to be a loss of muscular power due to an interference with the transmission of nerve force from its site of development in the central nervous system to the termination of the nerve fibres in the muscles.

As there may be interference with the *development* of nerve force as well as with its *transmission* this should also be included in the definition.

Again there may be a normal development of this force, but it may be wasted by an abnormal or useless expenditure.

Some of the hindrances to the proper development of nerve tone and to its proper use in the maintenance of that perfect equilibrium of all the organs and tissues of the body essential to health may be largely traceable to our modern civilization and environment.

Too much indoor life and too little sunlight and physical exercise are not unimportant factors to be considered in this connection.

The diet, too, common in this country is lacking in the elements essential to a proper physical development.

The plain and nutritious food common among our English and German ancestors is supplemented or wholly displaced by such as will please the palate regardless of consequences.

A diet containing a liberal use of milk with the proteid and fatty ingredients, together with such other easily digestible articles as may serve to complete the list of elementary or proximate principles is essential to the promotion of vigorous health.

Why this apparently growing tendency in all acute diseases to heart failure, lung paralysis and death from nerve exhaustion?

If, perchance the patient may have withstood the run of the disease, why, in so many cases the slow convalescence, the lingering paralysis or other sequelæ?

Is it not often traceable to the conventional rules of life as practiced by those primarily afflicted or by their ancestors?

The sowing of "*wild oats*" by young men too often results in corrupted blood, nerve exhaustion and ruined health, of which he alone is not the sufferer; but how often the fruit of his folly becomes the source of physical debility and suffering to his offspring.

The criminality of such a legacy is beyond measure.

Purity of life is all important in the promotion of the health, not of the individual only, but of those who are to share in his constitutional tendencies.

Wine bibbing and libertinism are probably at the base of many forms of nervous disease, hereditary or acquired, and notwithstanding the general knowledge of this fact, among the young men, these evils go on unabated, and true to the law of cause and effect, their consequences keep pace with them, so that it may be asserted that at no time in the history of the world have nervousness, excitability and brain exhaustion been so prevalent as at the present.

How many young men, especially of wealth, are reared in indolence, which is the great progenitor of vice.

They should be taught, by precept and example that labor, with brain and muscle, is not only honorable, but essential to mental and physical development.

Successful labor, too, has so much of reward in itself as to have an exhilarating and beneficial effect, if it be not incessant and prolonged.

Inertia means debility, but activity means power, by increasing muscular tone and fibre.

Indiscretion in regard to the proper protection and care of the body and excesses of all kinds; notably, such as are indulged in at the table, the excessive use of tea and coffee, the use of tobacco and other narcotics, all have their baneful influence upon the nervous system resulting in wakeful nights, and consequent loss of repair, which finally ends in nerve exhaustion.

One, eminent in his profession, who outlived and outworked most of his contemporaries, said: "I have never been in a hurry; I have always taken plenty of exercise; and I have taken all the sleep that I needed." As a rule of correct living this is truly *multum in parvo.*

Rest is quite as important a factor in the development of a strong and healthy physique as labor, and no means is so complete and salutary in its influence as refreshing sleep.

It is during the hours of repose that much of the delicate and ever essential reparative process is accomplished, and by which we are enabled to arise each morning to renewed activity of mind and muscle. Other means of rest are also quite essential.

There are times when we should cause a break in the daily routine of affairs and substitute, for a longer or shorter period, as may be required, amusement for labor, the grove for the counting-room, the fishing- and the hunting-grounds for the office and the store.

Variety of work, too, is helpful, as when the brain is tired, give exercise to the muscles and *vice versa.* In short, there must be an alternation of activity and rest to all the organs and tissues to keep them vigorous and capable of the full measure of activity required for the maintenance of an average degree of health.

If definite rules are essential to a proper physical development among men, they are none the less important as a means of securing the best types of women.

An affectionate grandfather said to me not long since: "There lives near me an Irish family of eight children, apparently in perfect health, and the whole eight children have never received the care that has been bestowed upon this, my little granddaughter, not yet one year old."

This is no isolated case. I venture the assertion that, in the his

tory of that Irish family, no female member on either maternal or paternal side ever constricted the chest by a corset, or encased herself in such tight-fitting garments as to prevent the development of muscles, a perfect expansion of the lungs, and a free circulation of the blood.

In studying the nerve supply of muscles it is interesting to note the safeguards nature has placed around these delicate fibres, which are the carriers of the most delicate sensations and of the most excruciating pains; or of the power which prompts and sustains any and all muscular activity by placing them where they would be the most secure from injury by pressure.

Notwithstanding this fact, it would seem that there is an effort on the part of most women to overcome these safeguards by compressing themselves in every possible way that the senseless whims of fashion may suggest.

Another very common error, and one not unfrequently productive of very serious consequences, is that of insufficient protection in the character and application of the wearing apparel.

Such material should be used as will prevent a sudden lowering of the temperature and excite chills; besides, the body should be evenly clothed instead of being massed upon the trunk, leaving the extremities half protected.

Again, too many women, never before inured to care, anxiety or responsibility of any kind, enter the married relation with all its new experiences, vexations and trials, which rest heavily upon them, and they fret and worry under the burden of their new and unaccustomed duties so that, ere the lapse of many years, their nervous systems have been debilitated or exhausted.

It would go far to prevent the repetition of the results mentioned if such persons would obtain the rest from household care and the renewal of nerve force, which comes from a few weeks annual outing. These frequent changes of air, of associations and surroundings, aid materially in promoting happiness and length of days.

How often we find mothers, devoted and affectionate, who seem to "love darkness rather than light," *not* "because their deeds are evil," but because they seem to think it essential to neatness and domestic economy that on every bright day the shutters should be closed and the blinds drawn down so that she and her little ones are

confined to the darkness of a living room, which is seldom blessed with the cheerful, inspiring and invigorating influence of the sunlight.

The effect of such a course may be to preserve the rich and beautiful colors of the carpets, to keep the darkened apartment a little cooler during the hot summer days, and to cause the last fly to seek other and more desirable quarters. But such mothers should remember that as roses never grow luxuriantly in the shade, and as plants soon lose their freshness without sun-light and pure air, so, too, there are other flowers that will not bloom in the darkness, such as cheerfulness, happiness and health.

The individual whose physical condition has been shattered by indiscretion, over-work or excesses of any kind, is an unfortunate subject in any of the severer forms of acute disease.

The prognosis in such cases should be guarded, and an unfavorable result anticipated, especially where there is a lack of assimilation and nutrition, or where there is a waste of albumen, the phosphates or other essential nutritive elements of the blood, as such subjects do not respond well to treatment, however carefully the remedies may be selected and applied.

Having thus far considered, at greater length than was at first intended, some of the causes which may lead to paralysis and some of the means by which such a result may be prevented, I desire, in concluding this paper, to make reference to three cases which may illustrate some of the points herein suggested.

Case 1.—Mrs. A. P., aged 36 years. The history of this case, one of post-febrile paralysis, was referred to in a paper which I read one year ago on the subject of typho-malarial fever, for the especial purpose of illustrating the beneficial effect of potassium phosphate in controlling the fever after a severe course of nine weeks' duration. As stated in that paper, paralysis of the lower extremities followed.

Sensation in the muscles of the lower extremities was unaffected except by an increased hyperæsthesia, while motion was entirely absent at first, with only slight improvement after a period of six months.

Prior to the attack of fever this patient had spent several weeks of anxious watching at the bedside of a sick child; besides, other domestic cares had been unusually trying.

It was noticeable, too, that there was a disposition to fret and worry over trifles and to magnify every difficulty until it seemed an insurmountable barrier. Matters that ordinarily occasioned no fear now excited the gravest apprehension.

This precursory condition of the nervous system, the large percentage of albumen in the urine throughout the course of the fever, and the fact that an elder sister had some years previously suffered from a severe and protracted paralysis following diphtheria, should, in this case, have prompted a guarded prognosis or led to the anticipation of the final result.

There were present in this case the following symptoms: Loss of memory; very acute sense of smell; stitches in the region of the heart, extending to the small of the back; great weakness of the knees; restlessness in the lower extremities, with a sense of stiffness in them, as if bandaged; aversion to rubbing or bathing; heat of the upper part of the body, with cold feet.

Passive motion was practiced very persistently from the first. There was great aversion to the use of the battery, and for this reason it was discontinued.

Several remedies were used without any very apparent benefit, until anacardium was given on the foregoing indications, and from that time improvement became more rapid, and continued until the patient was fully restored.

Case 2.—Frederick A., aged 17 years, was attacked with what was reported to be a rather severe type of diphtheria, about the 15th of August, 1889. He was treated by an Allopathic physician at the City Hospital, where he received the care of a thoroughly competent nurse.

On the third day of November I was called to take charge of this case, and found him suffering from diphtheritic paralysis, which began to develop about two weeks subsequent to the disappearance of the local manifestations of diphtheria in the throat, and had increased in severity from that time until the date above mentioned.

It was difficult for him to sit alone in bed, and quite an exertion for him to feed himself.

He could not bear any weight upon his feet, and motion in the lower extremities was almost wholly absent.

The local treatment in this case consisted of hot bathing of spine

and extremities, careful and persistent kneading of muscles, and the application of electricity.

I prescribed nux vomica, to be given for a few days for the especial purpose of overcoming the effect of excessive drugging, when causticum was given, owing to the following indications: Partial paralysis of tongue and muscles of deglutition, with stuttering, difficult and indistinct speech; sense of burning in the urethra when urinating; heaviness and weakness of the arms, with trembling of the hands and numbness of the fingers; at times desponding, and again cheerful and merry.

The improvement was at first slow, and later very rapid, so that he left the hospital after five weeks' treatment, almost fully restored.

CASE 3.—Lizzie T., a bright girl, a little over three years of age, attracted my attention last winter while treating another member of the family.

I learned from the mother that when the child was about ten months old she lost entire motion and sensation in both lower extremities.

Prior to this attack she had manifested more strength and vigor than had been common to the rest of the children in the family when of a similar age, so that she had commenced to stand upon her feet by the aid of chairs and other objects in the room.

The paralyzed condition was preceded by considerable febrile excitement which was attributed to the development of teeth, and consequently no physician was consulted until after the development of the paralysis, at which time she manifested no evidence of pain on pinching or pricking with a needle the muscles of either limb.

After a few months sensation returned in the left limb, and after a period of nearly two years more, the time when I first examined the case, there was only slight motion in this member, with almost entire absence of both sensation and motion in the right limb.

There was extreme atrophy of the muscles of both limbs, with well-marked diminution of the temperature, and some deformity.

Very few symptomatic indications could be gathered, among which were the following: Easily frightened and offended; perspiration on the back part of the head; upper part of the body fat; a flaccid condition of the extremities and coldness of the feet.

Prescribed calcarea carbonica and advised that massage be practiced several times daily, with the occasional use of the battery.

Some two months since I secured passive motion of the limbs by the use of a tricycle, strapping the feet to the pedals and having her wheeled about for several hours each day.

She can now work the pedals herself on a smooth and level sidewalk, an exercise in which she takes great delight; besides, she can now stand upon her feet with but very little assistance.

There is a gradual development of the muscles, an increased elevation of the temperature of the limbs, and such other general improvement in the case that final recovery seems now to be well assured.

To review, briefly, we have in the first two cases the hyperæsthesia and other symptoms indicating the spinal origin, besides the anæmic condition in both which naturally prompted a gloomy prognosis and served to prevent rapid improvement at the beginning.

The last case is reported for the especial purpose of showing that infantile paralysis which has continued for one year or more, is not always hopeless, as is generally asserted by the various authorities upon the subject.

Careful remedial selection, a nutritious diet, the tonic effect of electricity, aided by massage of the affected muscles, and the persistent and systematic exercise of the paralyzed members, will often bring about very gratifying results in obstinate and apparently hopeless cases.

PULMONARY FIBROSIS A RESULT OF THE CLIMATIC INFLUENCES OF SAN DIEGO, SOUTHERN CALIFORNIA.

BY JOSEPH RODES, M.D., SAN DIEGO, CAL.

The case I bring to your notice is one that nature, through sudden death from another disease than phthisis pulmonalis, allowed me to view pathologically. But it is the daily experience of most of

the Southern California physicians, by means of physical signs, to note similar results to lung destruction as those enumerated below.

The patient, a young woman with a marked family history of tuberculosis, was brought up in the East, and there went through the various stages of a pulmonary consumption. When nearly at death's door, she was taken to Denver, Col., but did not improve very much, owing to too small an amount of normal lung tissue (as shown in the autopsy) for that elevation. From thence she was removed to San Diego, where she steadily improved until her lung symptoms were about nil.

Late one afternoon, while out carriage-riding, not properly clothed, she was taken with a sudden chill, attended with vomiting. Her temperature quickly ran up to 105°; pulse 110; respirations about 50 per minute; slight, dry cough; great shortness of breath; stitching pains in lower part of left lung; later, crepitant râles over this area. The shortness of breath was the most marked symptom; this rapidly increased for about two hours, when she died, apparently from asphyxia.

Post-Mortem Examination.—Right chest flattened to a slight degree generally. On removing the sternum and rib cartilages the pleura on the right side is found to be closely adherent. Further investigation shows the pleural cavity on that side to be completely obliterated; the lower part of the superior lobe of the left lung adherent over an area about the size of a silver dollar.

The right lung had evidently gone through the stages of tuberculous infiltration and suppuration some months ago. At this time there is no suppurative process going on.

As was mentioned before, the pleural sac is completely closed by a previous general pleurisy.

There is, apparently, not much shrinkage of lung tissue, owing to its gradual metamorphosis into a compact, dark gray, homogeneous, fibro-cartilaginous mass, whose continuity is only interrupted by dilated bronchial tubes. The latter were probably dilated by the contraction of the connective tissue towards itself and pleura and from the tube walls. Probably this curative fibro-plastic process, acting in excess, had also reached the parts that were free from original ulceration, and thus brought about the total transformation of the entire lung into an inert mass of fibro-connective and fibro-car-

tilaginous tissue, without leaving a vestige of the pulmonary vesicles remaining. Under the microscope, this tissue presents a fibro-nucleated structure of varying coarseness. No Koch's bacilli could be detected in sections stained by the Weigert-Ehrlich method.

The left lung, at the lower part of the superior lobe, presents more recent pathological changes. Here we find a cavity about the size of a hickory-nut, invested in its whole circumference by thick fibro-connective tissue. Surrounding this is a narrow zone, in which the alveolar walls and the inter-alveolar tissue are very much thickened by a fibro-plastic material. Another search for tubercle bacilli is fruitless.

The middle and lower lobes of this lung present an intense engorgement of the capillaries of the bronchioles and the alveoli. Within the air-cell cavities and the terminal bronchi there is an abundant fibrinous exudate; in short, all the pathological signs of a beginning croupous pneumonia.

Was this not a strange coincidence—the supervention of a pneumonia in a case of only one lung, and even that one crippled in almost every part except the most frequent pneumonic area? Although every thing was done to avert the final result, death, was it not inevitable?

When this woman arrived at San Diego she was rapidly failing. While here, she did not receive any medicine, nor, in fact, any kind of advice or treatment; but, as I said before, this is only one case out of many similar ones, barring the complication of pneumonia.

Am I correct in attributing this cure of the original lesions to a climatic one?

BUREAU OF PATHOLOGY AND PATHOLOGICAL ANATOMY.

"The Pathology of Chronic Alcoholism," by W. K. Ingersoll, M.D.
"A History of Bacillus Tuberculosis," by R. W. McClelland, M.D.

THE PATHOLOGY OF CHRONIC ALCOHOLISM.

BY W. K. INGERSOLL, M.D., PHILADELPHIA.

In considering the pathological conditions existing in the organism resulting from the alcohol habit, I wish to trace as far as possible the influences and states leading up to those changes which this habit produces.

The different effects of the different alcohols are not definitely known, so we consider those effects produced by the whole group found in the usual beverages or alcoholic mixtures.

If a white blood-corpuscle, under favorable surroundings and in a liquid media containing a small percentum of alcohol, is examined, you may note an increase in its ameboid motion. Now, if an increase of alcohol is added, we find the corpuscle becomes white or opaque and all motion ceases. In the first place, there is an increase in cell activity and motion, and, secondly, a stoppage of all activity and coagulation of the cell protoplasm. The first effect is undoubtedly at the expense of cell force and material; the second is due to the influence that alcohol has on all albuminous substances, by the abstraction of water producing coagulation. There is a peculiarity in this coagulation of protoplasm in the human organism; it is not stable. By the addition of water the cell may be brought back to a life of activity; probably not equal to the activity that existed before it was influenced by alcohol. We may refer many of the pathological changes to be due to action upon the individual cell, as on the white blood-corpuscle. The histo-chemical changes are not understood, but from inferences made upon excretion we judge the proper metabolism

of the cell is interfered with ; and as there is a lowering of temperature when the system is profoundly under the influence of alcohol, we judge that interference consists, in a measure, to improper oxydization of some compounds. If this is true, we may expect to find retained within the system products of waste material, which is the case.

The first abnormal change made upon the organism from the imbibition of alcohol is upon the stomach, and consists first of an increase in the flow of gastric juice (providing the quantity of alcohol is not too great) from an increased cellular action in the cells of the peptic glands; but, the quantity being greater, the digestive power of the secretion is less (when we consider the quality alcohol has of coagulating all albuminoids), and hence an indigestion of peptinoids. At the same time alcohol, having such an affinity for water, passes, by a process of osmosis, through the walls of the small vessels in the mucous membrane into the general circulation. Now takes place a constitutional or general action, added to the local action. The force of the heart is increased ; the small arterioles and veinlets, which have been locally influenced by the alcohol, with the added pressure from the heart, become dilated, and a passive congestion of the mucous membrane takes place. This passive congestion probably would take place even though the heart was not made more active on account of the weakening influence on the individual smooth muscle fibres running about the bloodvessels, as also a paralytic action upon the vaso-motor nerve filaments.

After repeated congestions of the vessels of the mucous membrane under the influence of alcohol, the congestion becomes constant, and the whole mucous membrane swollen. In the mucosa a few white blood-corpuscles find their way into the connective spaces, fix themselves, and ultimately become fully formed connective tissue fibres. These fibres of connective tissue are added, in great measure, to the adventition of the vessels, being an effort of nature to strengthen them against these congestions. This process takes place both in mucosa and submucosa; and after a time the new connective tissue fibres contract, and by their pressure interfere with the free functional activity of the peptic and pyloric glands.

In the stomach we find a condition which exists the whole length of the alimentary canal, only to a lessened degree.

In the liver the pathological changes are most constant when we consider that all blood from the intestines is passed through the liver before getting into the general circulation; we see the reason why the liver should so often suffer such change. The passive congestion of the small vessels which takes place in the liver, as in the stomach, by repetition becomes constant. The leucocytes permeate the walls of the capillaries, form into new connective tissue, contract, and squeeze out the vitality of the essential epithelial cells. This process of filling in with new connective tissue takes place most in the interlobular spaces, and also in the intralobular areas. In this condition the liver becomes hard, often slightly contracted, and is light in color when cut. The contraction takes place in spots, making the surface uneven, hence the name hob-nail liver. If the quantity of alcohol is great, and its effect at once toxic to a great degree, there may no new connective tissue be formed. The essential epithelial cells of the parenchyma lose their functional activity, and partly undergo a degeneration. In this condition the liver is swollen, full of blood, soft, and dark bluish-brown in color.

The kidney suffers, as the liver, in an increase of connective tissue in the pyramids of Malpighi and Ferrin, resulting in a contracted kidney or interstitial nephritis.

The effect of alcohol upon the heart and bloodvessels is both primary and secondary. Primarily upon the fibres of the heart muscle itself we find we have the stimulating influence of alcohol upon the white blood-corpuscle alone, without the intervention of any nervous stimulus. This direct action exists for the smooth fibres in the media of the bloodvessels and the heart itself, without the intervention of brain, spinal cord or nerve ganglia. We base our conclusion upon the fact that the heart beats in cases of death resulting directly from alcohol, some time after the breathing has ceased and all other functional action has stopped. There is a predisposition to fatty degeneration of heart muscle, with atheroma of coronary artery, but these changes are probably not due to the alcohol habit directly, but to the impaired processes of digestion and assimilation.

There are few changes that can be noted in the macroscopical and microscopical appearance of the brain. There is the same passive congestion which we find in the other parts of the body, but little, if any, increase in connective tissue. The ganglion cells may show

some slight changes, but not constantly. The symptoms noted in chronic alcoholism are due probably to the direct toxic effect. Those symptoms encountered in delirium tremens or mania-a-potu are a result of a passive congestion, with an insufficient amount of pabulum to satisfy the normal requirements for the functional activity of the ganglionic nerve cells.

A HISTORY OF THE BACILLUS TUBERCULOSIS.

BY R. W. MCCLELLAND, M.D., PITTSBURGH, PA.

FEW subjects are of more absorbing interest to the profession than that of the ætiology of phthisis. Any new light which may be thrown upon the inner workings of this great scourge is sure to command immediate attention.

The discovery of the tubercle bacillus as the causative factor is a matter of recent history, and marks a great epoch in the progress of medical science. A hundred years ago the identity of the *tubercle* as associated with phthisis, was first discovered by Baillie. Up to this time the word tubercle referred to any and every small nodule wherever found, but was not identified in lung tissue. From the days of Hippocrates consumption was known only as a process of suppuration in the lungs, associated with a progressive wasting of the body. And nothing could exceed the graphic power with which some of these early writers described the well-known train of symptoms exhibited by the victims of this disease. While Baillie made the first move in the right direction, it remained for Boyle, a few years later, to determine the specific character of the tubercular virus. This discovery was the result of nine hundred consecutive autopsies, and was a most important step. It also decided the constitutional character of a disease, which was, up to this time, regarded as purely local. It also decided that the degeneration of lung tissue was nothing more than the local expression of a systemic malady. In other words, there was established the tubercular diathesis.

Later investigators, notably Laennec and Virchow, added much

to the common stock of knowledge. Laennec advanced the theory —which we now know to be sound—that the destruction of lung tissue was due mainly to a caseous degeneration of the larger tubercle masses. Virchow, on the other hand, held that caseation was not the characteristic process, that it could be found in any and all parts of the body, especially in gland structure. The real process from the beginning was one of *inflammation;* the tubercular masses and all other adventitious tissues were inflammatory deposits. Such was the influence wielded by this authority and the force with which his views were expressed that the scientific world was kept in ignorance for more than twenty years. But a great impetus was given to the work by the important discovery of Villemin, that tuberculosis could be conveyed by inoculation from man to animals. Other experimenters, also, showed that the same result could be obtained by causing the inhalation of dried and powdered sputum. This established the important point that phthisis is a specific and highly infectious disease; it also vindicated completely the views of Laennec as opposed to those of Virchow. And, more than all, it prepared the way for the wonderful revelations of Koch.

It must be remembered that up to the year 1878, through the influence of Virchow's teachings, tuberculosis was regarded as a possible result of any kind of inflammation. In 1880 the experimental use of atomized sputa, already referred to, once more revived the question of the specific nature of tuberculosis. The inoculation theory had fallen to disrepute, because other matters had been used, and apparently with the same result. Cohnheim now took up the work in a spirit of skepticism, but by a careful series of experiments was led to believe that former bad results were due to the use of mixed or impure inoculating matters. His conclusion was that "everything depends upon the virus." But the character of this virus, what it was that invariably produced the well-known train of symptoms, still remained a mystery. The fact of it was now well established, and a careful search was at once instituted for the specific causative element.

Aufrecht, in 1881, discovered several forms of micro-organisms, but his discoveries were regarded with incredulity. Such authorities as Flint, Roberts and Loomis, in late editions of their works (1884),

held to the theory of inflammatory action dependent upon diathesis. Thus all was still more or less shrouded in doubt.

In the meantime, a scientist was at work upon a series of investigations which were soon to set at rest all conflicting views, and establish the pathology of tuberculosis upon a firm basis. In 1883, appeared *The Ætiology of Tuberculosis*, the master-piece of Robert Koch. In this there is an acknowledgment of the important work done by Laennec, Villemin, and others, all of which established the specific character of the disease, and its inoculability. He then calls attention to the fact that these observers refer to a peculiar causative agent, whose identity is wholly unknown. To discover this germ, therefore, was the self-imposed task which he had undertaken. No success attended his efforts—the common experience of his fellow-workers—until he stumbled upon an organism which differed from all others in its behavior towards coloring agents. It refused to be colored by a certain class of dyes, but, when once the color was assumed, it refused to relinquish it for another. It was this property which revealed its identity; for, after having stained the whole field a deep blue, brown was superadded; as a result, the tissues readily took on the brown stain, allowing the micro-organism to stand out in bold relief. This peculiar germ was rod-shaped, always bent upon itself—and on mischief—and apparently motionless. The rods were found to be arranged in parallel rows, and generally concentric. Such is the appearance of the tubercle bacillus of Koch. Koch discovered this germ, isolated it, and by inoculation invariably produced the disease.

Therefore, he lays down the dictum that, as this germ is always found in all tubercular deposits, and when inoculated reproduces these deposits, like for like, we must regard it as the sole and only cause of the disease. This settles, once for all, the long-maintained theory of inflammatory action, and all other theories. It shows that consumption, so-called, is a highly infectious disease, and is probably communicated largely by the inhalation of dried sputa. The immense value of this discovery to mankind lies in the fact that the spread of this dread malady may be limited by the establishment of proper sanitary regulations.

BUREAU OF SURGERY.

"Pathology of Prostatic Diseases," by Carl V. Vischer, M.D.
"Tabulation of Forty-six Operations for Stone in the Bladder, with Presentation of Specimens," by C. M. Thomas, M.D.
"Flat-Foot," by J. W. Giles, M.D.
"Cases of Abdominal Surgery," by W. B. Van Lennep, M D.

PATHOLOGY OF PROSTATIC DISEASES.

BY CARL V. VISCHER, M.D., PHILADELPHIA.

It seems as though the prostate gland, although intimately connected with, and in fact a part of the uro-genital tract, is frequently forgotten or disregarded. Especially does this seem to be the case in the more acute forms of urethral disease, and only where a hypertrophy is possible or probable is it made the object of a more careful examination.

A few words as to the anatomy of the gland may not be out of place. The prostate is a symmetrical body composed of a median and two lateral lobes; the existence of the former, however, is said by some, never to be present in a normal gland.* Its structure consists of a dense stroma of unstriped muscular tissue, in the meshes of which are found tubular glands, lined with cylindrical epithelium.

It is tunnelled by the ejaculatory ducts, which open at the floor of the prostatic urethra on either side of the verumontanum, where also the ducts of the gland itself empty. It lies below and in front of the neck of the bladder, surrounding the beginning of the urethra for about an inch of its length, and is enclosed by a dense capsule, with the pubes in front and posteriorly the rectum. It is held in position by the pubo-prostatic and posterior layer of the triangular ligaments. The gland is almost completely surrounded by a plexus of veins.

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* Thompson, Morgagni, Lantorini, etc.

It is easily conceivable, owing to the relation the gland bears to the urethra, that it is readily accessible to any inflammatory process that may be going on in the canal, not to mention those that may rise primarily in its structure. Aside from the inflammatory conditions to which the prostate is liable, we may have those arising from altered nutrition, such as atrophy, hypertrophy, etc.; although comparatively rare, it may prove not the less interesting to give these a passing notice.

Atrophy of the Prostate, although infrequent, is sometimes met with in old age, when we find the glandular element to be the principal seat of the atrophy. It is also found in wasting diseases, such as phthisis, and where there is any pressure exerted as from a stone, tumor of the bladder or stricture, which, by causing a damming back of the urine, increases the pressure. It has also been found in the young, when it may be so marked as to cause incontinence.* Atrophy at times may follow an acute inflammation as in other organs. Double castration has also been known to produce this change. Thompson has shown that atrophy does not necessarily accompany old age any more than does hypertrophy, and that as a rule the gland remains about its normal size.†

Prostatic Hypertrophy is a condition that has been so exhaustively discussed, that any further remarks may seem superfluous. Pathologically, however, it presents a variety of forms which may prove interesting. It is probably the most common affection of the prostate found in elderly men. So that Sir Benjamin Brodie was said to remark that "when the hair turns gray and scanty the prostate gland almost invariably becomes increased in size." Hypertrophy, according to Thompson,‡ is never found before the 55th year, after which it is found in about 33 per cent. The most frequent form of enlargement is an increase of the stroma forming a tumor composed of fibro-myomatous tissue, analogous to those found in the uterus; this variety may reach quite a large size. Thompson§ speaks of having seen one as large as a small cocoanut. Another form of hypertrophy is where there is a glandular hyperplasia which in reality is

* Socin.

† Thompson on *Diseases of the Prostate,* 1873.

‡ Thompson on *Diseases of Urinary Organs,* 1883.

§ *Diseases of the Urinary Organs,* 1883.

a true adenoma and may undergo carcinomatous changes. In cases of glandular hypertrophy the ducts of the prostate are not infrequently involved and may be the cause of no little difficulty in catheterizing, the tip of the instrument being apt to enter the mouth of a duct.

Especially is this the case when a small catheter is used.

The diagnosis of prostatic hypertrophy, as a rule, presents but little difficulty. It is a disease of advanced life and is never found before the 55th year, after which it may give rise to a variety of symptoms, the principal one being difficulty of urination. This is no doubt a frequent symptom of several pathological changes, but where it is present in the young it is usually due to some inflammatory or nervous condition. In middle life it is commonly found in cases of stricture, but where these conditions can be excluded in those more advanced in life, it will almost invariably be found due to prostatic enlargement. The patient is obliged to pass water frequently, especially at night, the opposite being the case in stone. As a consequence of the hypertrophy there will be more or less retention of urine which sooner or later gives rise to a cystitis, which may prove the most difficult to manage. Subjective symptoms alone may, however, give rise to errors in this, as in most any other disease; therefore it behooves us to make a physical examination in every case of suspected hypertrophy, when, as a rule, it becomes an easy matter to recognize the form of enlargement we have to deal with. In cases of unilateral hypertrophy, the urethra frequently becomes distorted, forming a letter S; here it is where the greatest skill combined with no less patience and a very flexible catheter is required to prove of avail, and, in fact, there are cases where even these measures are unsuccessful. In bilateral enlargement, the calibre of the urethra is also greatly diminished and may be obliterated, making catheterization impossible. Here as in the foregoing form, we may have such an increase in length of the urethra as to make it impossible to reach the bladder with an ordinary catheter. A prominent third lobe not infrequently leads to retention, acting as a valve over the internal urethral orifice; there are, however, cases reported where quite a large middle lobe caused little or no difficulty. Where it is possible to pass a sound into the

bladder, the intravesical condition may be determined quite readily, especially if this is combined with the rectal examination.

Malignant Tumors of the Prostate are rather rare; occasionally, however, we may find it the seat of a carcinoma or sarcoma. The former has been principally observed in the earlier years. Nyss described the growth as beginning from the tubular epithelium with relatively little change in the stroma, whereas, Birch Hirschfeld * found considerable hyperplasia of the stroma with round-celled infiltration, the carcinoma cells being usually found in nests or arranged in strings and mostly of the cylindrical variety. The growth consists at first of small, yellowish white nodules which protrude into the urethra and soon begin to ulcerate, and as a result of which we have more or less severe hæmorrhages. Carcinoma of the prostate, as that of the bladder, is seldom followed by metastasis, the disease spreading by continuity, and so involving the neck of the bladder, seminal vesicles and rectum.

Sarcomata, although seldom, are most commonly of the variety known as lympho-sarkom, one case of such being reported as occurring in a child of two years of age.†

Tuberculosis of the Prostate is unusual, excepting as a secondary involvement of tuberculosis of some other portion of the genito-urinary tract, especially the epididymis, and is characterized by a nodular enlargement, the nodules being smaller than those sometimes found in fibrous hypertrophy and undergo cheesy degeneration, oftentimes breaking through and discharging into the rectum, bladder or urethra. The diagnosis is not difficult, as a rule.

Prostatic Concretions, accurately speaking, are only found in the ducts of the gland, and are almost invariably present in old prostates in greater or less numbers. They greatly vary in size from those that are to be seen microscopically only, to those of quite large size, T. H. Barker having removed one weighing over three ounces. The smaller ones are round or oval and formed in concentric layers. According to Paulitzky, the concrements are formed by the deposition of albuminoid substances around desquamated epithelium, which changes into an amyloid substance and finally calcifies.

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* *Pathological Anatomy*, 1887. † Birch Hirschfeld.

Stilling believes them to be formed from a hyaloid degeneration of the epithelial cells such as takes place after fevers. They may be so numerous as to cause complete atrophy of the gland, the stones remaining in the capsule as if in a sac (Adams). In general, they much resemble biliary calculi.

Cysts of the Prostate are very exceptional and are usually formed by a dilatation of the ducts caused by a stoppage from a concrement, or where there is a fatty degeneration of the epithelium lining the ducts, when it is known as a "milky prostate" (Rokitansky). There are a few cases of echinococcus of the prostate reported.*

Coming to the more important affections of the prostate and those which will claim our attention most, we have the inflammatory changes.

Prostatitis may be of two varieties, follicular and parenchymatous; each of these may be either acute or chronic.

Acute Prostatitis may be due to several causes, such as traumatism, excessive intercourse, masturbation, or mechanical irritation, as stone or astringent injections, but is by far more common as a sequence or accompaniment of urethritis. According to Montagnon and Eraud 70 per cent. of the cases are of gonorrhœal origin, when it usually is found to be of the follicular variety. Here the gland is but slightly enlarged and oftentimes but one lobe is found involved. The inflammation tends toward localization, as in most cases one or two nodules about the size of a pea can be made out by rectal examination, which either terminate in resolution or the formation of small abscesses that empty spontaneously into the urethra. This form of prostatitis is prone to develop at or about the same time that the inflammation invades the posterior urethra, which as a rule takes place the latter part of the third week, unless the process is precipitated by premature injection. The diagnosis of acute prostatitis may often be made by the presence of a constant desire to urinate, which is the more marked the more acute the inflammation is, so that in the more severe forms, the patient scarcely has time to respond to the call, the urine passing involuntarily. The discharge apparently remains unaltered, but if Thompson's test with two

* Lowdell, *Med.-Chirug. Trans.*, 1846, Vol. 29.

glasses be made it will be seen that the second glass is decidedly cloudy, perhaps as much if not more than the first; this is owing to well known reasons. If the urine in the second glass is allowed to precipitate the latter will be found to consist of mucus, together with numerous small hooked-shaped particles. On the addition of a few drops of acetic acid, the cloud may disappear, owing to the phosphates, an excess of which is frequently found in connection with this trouble. At the end of micturition the patient experiences sharp pains, which radiate from the prostate into the rectum, perinæum, and sometimes the testicles, and are due to the contractions of the neck of the bladder in forcing out the last of the urine.

Rectal examination reveals the condition previously described, together with marked tenderness. The disease tends toward resolution, unless influenced by some indiscretion on the part of the patient or otherwise, when it passes into the chronic stage.

Chronic Prostatitis, besides being due to the foregoing, may arise as a complication of chronic urethritis. When the gland may be decidedly enlarged or considerably smaller than normal, the structure becomes spongy and exceedingly vascular; in advanced cases we may have numerous small abscess formations, the mouths of the ducts are wide, containing mucus; besides these we may find numerous small cavities opening on the floor of the prostatic urethra, the mucous membrane of which is atrophied and highly vascular. The glandular epithelium undergoes cloudy swelling. As to the symptoms of chronic prostatitis, there are many in common with the acute form, only not as marked, such as the tenesmus, which causes a source of constant trouble, most every act, such as walking, sexual intercourse, etc., making the patient feel as though he must empty his bladder at once; this, although not as marked as the acute stage, seems to be more constant. Defecation is often accompanied by a thick milky discharge from the urethra, which many believe to be sperma, so that one frequently finds a supposed spermatorrhœa, is in reality due to a chronic prostatitis. Besides these we have symptoms of sexual irritation, which function is decreased, the patients often complaining that an orgasm is impossible or is accompanied by a sharp pain in the posterior urethra and rectum. Another, and indeed a very common symptom, is a premature orgasm, the patient having good erections but ejaculation takes place before the act can

be accomplished, immediately following which the organ becomes flaccid. Nocturnal emissions are also frequently complained of.

This is quite naturally followed by mental depression. In some inveterate cases of prostatorrhœa, spermatozoa are at times found with the prostatic fluid. There may also exist a general hyperæsthesia of the genital organs. Patients complain of sharp burning pains during micturition which may lead one to suspect acute inflammatory changes, or stricture, as not infrequently spasms of the urethra are present. Besides these, we may have many of the well-known symptoms of sexual neurasthenia. In regard to the diagnosis of chronic prostatorrhœa, it will suffice to say that the passage of a sound will elicit unusual tenderness in the prostatic urethra, and the secretion which is quite diagnostic of the trouble will be found adhered to the beak of the instrument on its removal, after which it can also be readily squeezed out by slight pressure along the deep canal. The test with the glass may prove the second portion of urine quite clear, but in it will be seen floating small hook-shaped casts of the prostatic ducts; this together with the subjective symptoms is sufficient on which to base a diagnosis.

Microscopically, the secretion consists of abundant pus cells, polygonal and cylindrical epithelium, together with the so-called Böttcher's sperm crystals which consist of fine needles, the base of which is composed of phosphatic salts, which Schreiner has shown to be pathognomonic of prostatorrhœa. To demonstrate these most satisfactorily it becomes necessary to obtain the secretion free from urine. A drop of one per cent. sol. of phos. of ammonia is now added to an equal quantity of secretion, which is allowed to dry slowly under a cover-glass.

Parenchymatous Prostatitis is usually the result of either one of the above forms or of traumatism. The gland becomes enlarged, at times so much as to cause partial or complete retention of urine. It is exceedingly tender, and gives a boggy sensation to the finger. Painful defecation is not an uncommon symptom. The disease runs a rather rapid course, either terminating in resolution or abscess formation in a week to ten days. In case of the former, the symptoms gradually subside; whereas in the more destructive form, the symptoms usually increase in severity until about the seventh or eighth day, when the patient is taken with a severe chill followed

by a rapid rise of temperature. Examination now reveals a semi-fluctuating mass, which may point and break in one of several directions, unless surgical interference gives free vent to the pus. Although the most frequent point of rupture is into the urethra (64 times in 102 cases, Legond), it may break into ischio-rectal space, rectum, peritoneal cavity, perinæum or burrow and point in the inguinal region or various other directions; one case being reported where it pointed at the umbilicus, so that at least this form of the disease is much more serious than ordinarily supposed. Of 114 cases tabulated by Legond, 34 resulted fatally. It is therefore advisable always to keep this in mind, and in every case of gonorrhœa with a sudden rise of temperature to carefully examine the prostate.

DISCUSSION.

Dr. Van Lennep said that hardly a month passed by in which he was not called upon to relieve a retention of urine due to prostatic disease. The difficulty in most cases he found to be that the physician had used improper instruments, usually a metallic or an English catheter with stilet. If the Mercier catheter had been used there would have been no trouble in most cases. This catheter should be passed down, with its beak looking upwards, in which case it will ride very readily over the obstruction. The enlarged mouths of the ducts can usually be avoided by using as large a catheter as possible. In cases that will not yield to the Mercier catheter, we may resort to a device of Ultzmann. Use an English catheter with a hyper-curve; then pull on the stilet as it rides into the bladder. Still another point is, that one hears much of the effects of self-abuse. Now, the speaker believed that self-abuse, as a cause of prostatic disease, sank into insignificance in comparison with gonorrhœa. He thought, therefore, that physicians should never, under any circumstances, take it upon themselves to advise illicit intercourse as a remedy for any ailment, real or fancied.

A TABULATION OF FORTY-SIX OPERATIONS FOR STONE IN THE BLADDER, WITH PRESENTATION OF SPECIMENS.

BY CHAS. M. THOMAS, M.D., PHILADELPHIA.

THE accompanying report of my experience in the removal of stone from the male bladder is offered the Society without extended remarks simply as a contribution to the statistics of this department of surgery.

	No.	Age.	Weight.	Result.[1]
Lithotrity,	1	35	60 grains. (4 sittings.)	Recovered.
"				
(Old method.)	2	40	55 grains. (5 sittings.)	"
" "	3	50	48 grains. (4 sittings.)	"
Rapid Lithotrity,	1	40	360 grains.	"
"	2	54	58 "	"
"	3	52	24 "	"
"	4	48	85 "	"
"	5	35	145 "	"
"	6	60	1875 " (2 sittings.)	"
"	7	40	80 grains.	"
"	8	28	65 "	"
"	9	40	88 "	"
"	10	57	100 "	"
"	11	68	110 "	"
"	12	37	55 "	"
"	13	38	320 "	"
"	14	40	120 "	"
"	15	50	90 "	"
"	16	48	210 "	"
Lateral Lithotomy,	1	28	480 "	"
"	2	11	195 "	"
"	3	5	30 "	"
"	4	6	20 "	"
"	5	13	50 "	"
"	6	10	320 "	"
"	7	10	100 "	"
Median Lithotomy,	1	55	70 "	"
"	2	48	35 "	

	No.	Age.	Weight.	Result.
Median Lithotomy,	3	25	Incrusted syringe nozzle.	*Died.*
Suprapubic Lithotomy,	1	67	1440 grains.	Recovered.
" "	2	62	300 "	"
" "	3	47	200 "	"
" "	4	70	170 "	*Died.*
" "	5	63	960 "	Recovered.
" "	6	8	180 "	"
" "	7	70	200 "	"
" "	8	62	720 "	"
" "	9	60	300 "	"
" "	10	65	960 "	*Died.*
" "	11	62	300 "	Recovered.
" "	12	8	210 "	"
" "	13	62	800 "	"
" "	14	48	280 "	"
" "	15	25	360 "	*Died.*
" "	16	32	1200 "	Recovered.
" "	17	54	230 "	"

Of the nineteen stones removed by crushing, but three were done by the old or "many-sittings" method, and all were small concretions (60, 55 and 48 grains). In the first of these cases, although four crushings were done, the removal was probably not complete, as a persistent cystitis was reported as existing five months later. In all three the treatment was prolonged over from three to six weeks' time, and was accompanied by more or less suffering from cystitis. This presents a marked contrast with the showing in the list of 13 cases operated by the Bigelow method, in which the stones ranged in weight from 24 grains to 1875 grains (average about 250 grains), and when but one sitting was required in each, except in the largest, when the crushings were done ten days apart; in the first of these, 544 grains were removed; and in the second, 1331 grains. The recovery in this case occupied three weeks; in all the others the patient was about in ten days, while in several instances there were no symptoms of bladder irritation after forty-eight hours. For small medium-sized stones lying free in the bladder and a capacious urethra, a more ideal operation than this could scarcely be conceived.

Of the cutting operations, seven were done by the lateral perineal method. The largest stone in this class weighed 480 grains, and was removed from the only adult of the series. Case No. 3 has still a small urinary fistula; the others have made perfect recoveries.

The last of the three median lithotomies, that for removal of an incrusted syringe nozzle, I have perhaps improperly placed among the fatal results, as his death followed a pleuritis, contracted from exposure just as the wound was almost entirely closed, and after he had been out of his room several days.

The suprapubic operation was done seventeen times. Among these I have recorded three deaths, although in the last of these the patient died of amyloid kidney several weeks after his return home; the sinus for operation, had, however, not entirely closed. In one of this series in which there is an almost complete obstruction of the urethra from prostatic hypertrophy, a urinary fistula is still present two years after operation.

If one considers that in these 17 cases, 12 of them were over 45 years and 9 over 60, that more than half of the calculi were over the medium size, and that renal complications existed in 50 per cent. of cases, the loss of 3 out of the 17 may be looked upon as an unusually low fatality, and not a mean argument in favor of the more general adoption of this operation for stone.

The specimens were shown the Society.

FLAT-FOOT.

BY J. W. GILES, M.D., PHILADELPHIA.

The orthopædic surgeon is not infrequently consulted about a painful deformity of the foot, which, as an acquired affection, is exceedingly common, and as such has not, until the past few years, received the attention it merits.

Flat-foot is characterized by a lowering or obliteration of the normal plantar arch, together with a greater or less degree of eversion of the front part of the foot. Like other forms of talipes, or club-foot, it may be congenital or acquired. As a congenital affection, in its mildest form it is often found at birth, but seldom in such a degree as to be considered pathological. It is, moreover, a well-accepted fact that all infants on commencing to walk are flat-footed,

and do not acquire a perfect plantar arch until they have exercised some time, and the leg muscles have become developed.

It is most common as an acquired affection from infancy to adolescence, seldom becoming a serious deformity until the latter period, and always occurring in one of two forms, either a paralytic, as valgus, resulting from poliomyelitis anterior, or an acquired valgus, resulting as a sequelæ of burns, traumatism, osteitis of the tarsus, ankle-joint disease, or muscular and ligamentous relaxation as associated with rachitis, or more frequently induced by improper positions of the feet during rest and motion.

Many theories have been advanced as to the cause of acquired flat-foot. The one most commonly held, at the present time, is, that excluding traumatism and those cases directly attributable to disease of the tarsus, ankle-joint, or rachitic deformity, the great majority of cases of acquired valgus can be attributed to faulty positions of the feet during rest and motion. This theory, as advanced by Lane, Ellis, Whitman, and others, is about as follows: The foot is supported not only *in* but also *by* the exercise of its functions. The muscles, which by action move, in action sustain, the structure. In early life they also develop the form. Ligaments are insufficient to resist tension when the tension is continuous or prolonged.

Muscles, developed by action, tend to remain taut and firm when not in action, and so, by keeping up continuous pressure, modify the bony contours. A failure of muscular support tends to deformity from yielding of ligaments.

In good walking, the heel is raised from the ground by the long flexors acting with the peronei and tibialis posticus at the same time. While the long flexor muscles press the toes against the ground they tend to lift up the heads of the metatarsal bones forming the anterior pillar of the arch, which thus dance, so to speak, on tight ropes. Injurious pressure against the ground is thus prevented when the weight is borne by the anterior pillar only. This action relieves all strain on the ligaments beneath the tarus, while drawing the two pillars towards each other and throwing the arch upwards, just as tightening a bowstring increases the bending of the bow.

The hollow parts of the two feet form the two halves of a dome, which, however, is shaped somewhat irregularly. The posterior

pillar of each arch, or half-dome, is formed by the projecting heel, which abuts on the ground, without lateral expansion on the ground-line. The anterior pillar, formed by the heads of the metatarsal bones, is unevenly extended on the ground-line by the varying length of the toes. The keystone of the arch is formed by the astragalus, on which the legs directly rest, and it is through it that the downward pressure is transmitted to the heel posteriorly, and to the toes anteriorly. The arch is furthermore strengthened by the "tie-rod" arrangement of the muscular, ligamentous and fascial structures of the plantar surface of the foot, which, bearing the same relation to the anterior and posterior pillars of the arch that the bowstring does to the bow, serve to maintain it in its normal rotundity.

When the foot, with the sole flat on the ground, is everted, the toes turned out, the scaphoid bone is rotated downward, and the ligament uniting it to the os-calcis is relaxed. Thus, the calcaneo-scaphoid is the support of the head of the astragalus, which, therefore, is the less supported, and has, in this position, the greater tendency to sink. If, then, the key to the arch loses its support, the arch can only be maintained by a contraction or shortening of the "tie-rods" which connect the pillars. If, however, the foot be inverted, the toes turned inward, the scaphoid bone is rotated upward, and the ligament in question tightened. This gives the head of the astragalus a firmer support, and the maintenance of the arch is not dependent wholly upon structures which are liable, under long-continued pressure, to stretch or rupture and allow a sinking or obliteration of the arch, giving rise to the deformity under consideration.

Quite recently Drs. Gibney and Abbé have reported three cases of flat-foot which appeared to be dependent on ingrowing toe-nails, and were cured by the removal of the offending nails in two cases and the excision of a tender cicatrix in a third. To me it would appear that the muscular spasm, pain, and apparent deformity were caused not directly by the sensitive toe, but indirectly by the foot being held in an everted position to escape painful shoe-pressure. Patients suffering from acquired flat-foot have an attitude and walk that is characteristic. They stand with the feet everted, resting on the inner side of the sole, with the knees in a fixed valgoid position, and walk with a difficult, heavy gait, the knees flexed and the feet placed

everted and flat upon the ground in an uncertain, careful manner. Such patients have an expression of anxiety, tire easily, and complain of pain upon walking or standing. This pain varies, according to the severity of the case, from a dull ache to a sharp, lancinating pain, which shoots up the legs and sometimes even to the thighs. Associated with the pain we will find marked tenderness over the astragalo-scaphoid articulation at the inner border of the foot; also, sensitive points in front of the inner malleolus and at the base of the first and fifth metatarsal bones.

On inspection the plantar arch will be found to be lowered, and, in severe cases, completely lost. The foot will appear longer and broader than normal, and will seem to have been distinctly displaced outward, bringing the internal malleolus nearer to the ground, and rendering it more prominent than normal.

It would seem that little difficulty would be experienced by the physician in recognizing this affection, yet I know of no other deformity which is more frequently overlooked. Several cases have come into my hands which had been treated for rheumatism, and it has been frequently mistaken for inflammatory conditions of the tarsal or metatarsal joints or ligaments.

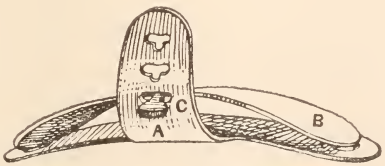
It seems to me that, taking into consideration the frequency with which flat-foot has been mistaken for other affections, that all cases complaining of pain at the inner ankle should be examined with a view of at least excluding that condition.

The treatment of acquired flat-foot varies considerably, according to the degree. In the milder forms, where we have no distinct displacement, but simply a weakening or relaxation of the muscular and ligamentous structures, the cultivation of a proper walk, *i.e.*, with little or no outward divergence of the toes, the application of proper shoes and certain foot gymnastic exercises which tend to develop and strengthen the muscles, such as walking across the room half a dozen to twenty times, morning and evening, on the toes and balls of the feet; then, by way of variety, on the outer borders of the feet. These, supplemented by frequent cold baths, massage, and electricity, will, in many cases, be sufficient.

In more severe cases, where we have dislocation accompanied by muscular spasm, or where permanent changes have taken place in he bones and soft parts, the proper treatment, as advised by Whit-

man, will be reduction under anæsthesia and the application of some means of support to the arch. By his method, the foot, after reduction, is placed in a position of varus, and retained by plaster of Paris bandages until the spasm and congestion have disappeared. To obtain retention he has a plaster cast of the foot taken, from which an iron pattern is made; on this a brace of thin, tempered, unyielding steel is moulded. This brace is designed to be worn within the shoe, and he claims that by it retention is obtained without discomfort to the patient, while it aids in assuming a proper walk and does not interfere with the normal movements of the foot or the action of the muscles. While no doubt this brace is very efficient and has received the endorsement of many orthopædic surgeons, yet its cost places it beyond the reach of our poorer class of patients.

With a view of obtaining a cheap and, at the same time, an efficient, plantar brace, I have had one constructed by Mr. A. G. Gefvert, of this city, which apparently meets the requirements desired. It has been used in about thirty-five cases, and in all has given satisfaction.



This brace is designed to be worn within the shoe. It consists of two parts, a somewhat inverted, ⊥-shaped piece, A, which is riveted to the sole of the shoe and furnishes support for B, an ovoid piece of thin steel which extends from the bearing-point of the heel to the heads of the metatarsal bones. The plantar plate, B, is furnished with a projecting arm, C, which is attached to A. The stem of the inverted ⊥ being supplied with a series of clover-leaf shaped holes, which loosely retain the rounded head of the arm, C, thereby preventing "binding" of the foot, and at the same time permitting flexion and extension.

Various other devices for furnishing supports to the arch by means of pads of leather, felt, rubber, and other like materials attached to the inner or outer side of the sole; steel bars, springs, etc., added to specially-constructed shoes, have been recommended

by different surgeons. With these I have had little experience. In one case in which elastic support was tried it either failed to sustain the arch, or caused pain by pressing too forcibly.

Building up the shoe at its inner side, as recommended by Thomas, has met with a fair degree of success. The same object, however—that of compelling the patient to walk on the outer side of the feet—can be attained by the use of the Whitman brace or the one I have shown you, and without the peculiar shape of the shoes calling attention to the deformity; this, in sensitive subjects, is important.

Operative measures for the relief of flat-foot have been advocated by various writers. They comprise principally the resection of the tarus or portions of it. Phelps's idea of excising a portion of the muscles, fascia and skin of the sole, with union of the ends, to shorten the "girders," has been favorably advocated by some surgeons. Probably supra-malleolar osteotomy, as advocated by Trendelenburg or Hahn, seems the most promising operative measure; but even that should only be undertaken as a last resort, when all mechanical means have failed.

CASES OF ABDOMINAL SURGERY.

BY W. B. VAN LENNEP, M.D., PHILADELPHIA, PA.

In looking over my abdominal work for the past year with a view of preparing a clinical report on the subject, it seemed to me that, instead of attempting an account of all the sections done, it would save time and, I trust, be more interesting to select only those cases that present peculiarities out of the usual run.

Of eight sections for tumors three will come under this category:

(1) *Enormous Fibro-Cystic Tumor of the Uterus; Hysterectomy.*

Mrs. B., aged 44, operated for Dr. E. M. Howard, of Camden, N. J., October, 1889. For six years has noticed enlargement of the abdomen; it was then about the size of pregnancy at term; the growth was slow at first, rapid of late; there was distinct fluc-

tuation; the length of the uterine cavity was normal and turned to the right; the menses long lasting, but not profuse. Section showed a cyst covered by uterine tissue and continuous with the uterus. Tapping failing to empty it, an incision was made, and its structure found to be a mass of small cysts filled with a slightly gelatinous fluid. As this did not materially decrease its size, the abdominal opening was enlarged almost to the ensiform cartilage, and the tumor turned out. An Esmarch tubing was then thrown around the cervix and the tumor, uterus and appendages amputated as low down as possible. A V-shaped piece was taken out of the stump and the flaps brought together by a continuous suture, layer by layer. After the tubing was removed interrupted sutures were applied to any bleeding points. The abdominal wound was closed, leaving room at its lower angle to draw up the stump, to which the peritonæum and then the skin were stitched. She made a good recovery, some of the stump sloughing, until now only a very small cicatrix remains. She has been in excellent health ever since, barring the annoying and characteristic symptoms of the climaxis.

These large, fibro-cystic uterine tumors are of sufficient rarity to warrant their being recorded, and are usually operated under the impression that they are ovarian cysts. I know of one very able surgeon who, in a similar case, having neither rubber tubing nor écraseur, closed the abdomen without removing the tumor. The method used is, to my mind, preferable to the écraseur, and the suspension of the stump in the abdominal wound has since been advocated by Kelly. It is also less dangerous than dropping the closed stump back into the abdomen. The specimen was presented to our County Society October 10, 1889.

(2) *Multilocular Right Ovarian Cyst; Glycosuria; Excision.*

Mrs. L., aged 56, operated for Dr. F. W. Boyer, of Pottsville, Pa., October, 1889. The tumor, which had been developing for a year, consisted apparently of two cysts, a larger one filling the abdomen and a smaller one the right pelvis. The customary urine analysis revealed a quantity of sugar and a specific gravity of 1045. Section corroborated the diagnosis of two principal, with a number of smaller cysts, containing in all about nine quarts of fluid and springing from the right ovary. A beginning cyst was found in the left ovary, which was tied off. There were no adhesions. The

operation occupied twenty-three minutes from the first incision to the completion of the dressing. Recovery was uninterrupted and she was home in less than a month with a marked diminution in the glycosuria. This has since disappeared and has not recurred.

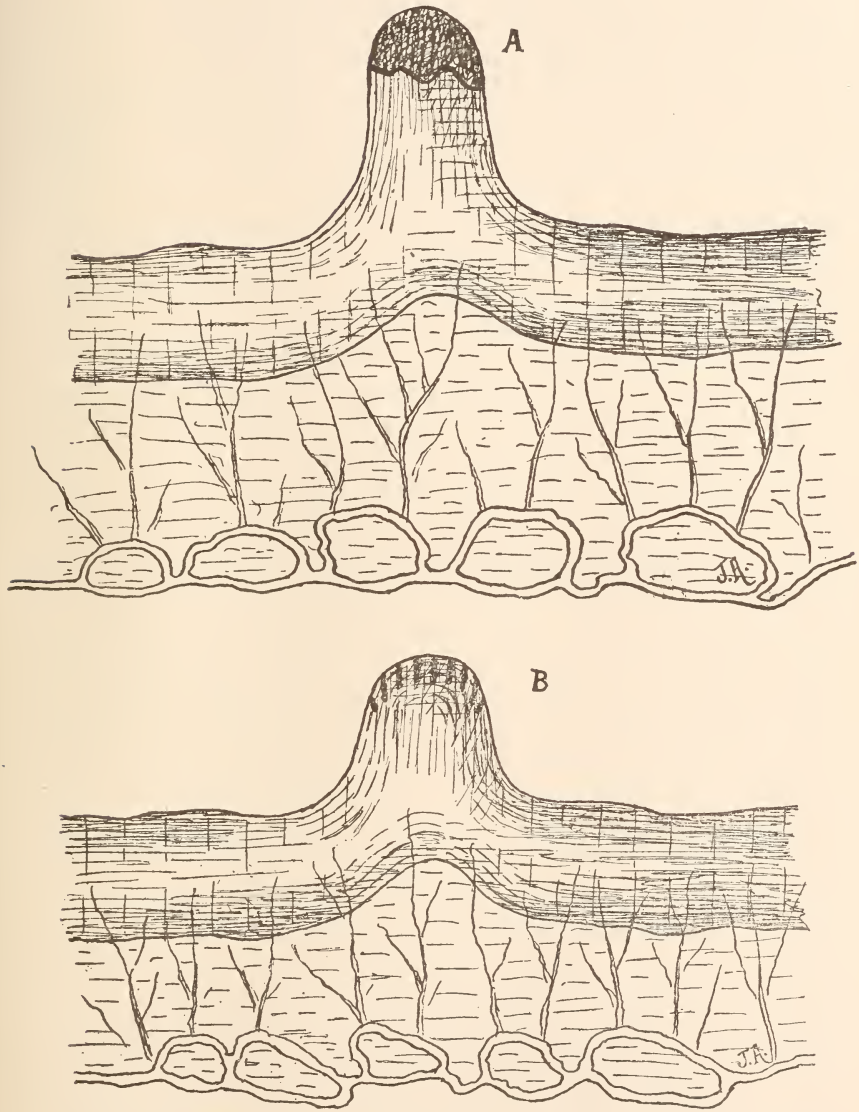
This case fortunately presented no difficulties. The glycosuria, a contra-indication to most capital operations, caused me considerable anxiety, but the rapid growth of the tumor and the inconvenience it was causing decided me in favor of the life-saving operation. This was done as quickly as possible, and the absence of complications during and after it undoubtedly aided in bringing about the favorable result. The disappearance and non-recurrence of the sugar without dietetic treatment would point to the tumor as a probable causative factor.

(3) *Colloid Cyst of Left Ovary; Peritoneal Infiltration; Ovariotomy.*

Mrs. V. H., aged 58, referred to me by Dr. B. B. Gumpert of this city, and operated April, 1890. The tumor extended to half way between the umbilicus and the ensiform cartilage; was freely movable; there was indistinct fluctuation; the uterus was prolapsed and could be separated from the tumor; the cavity was scant three inches long; there was marked cachexia and an induration in the abdominal wall on the left side. After section a quantity of ascitic fluid was let out, and, as the trocar would not evacuate the thick, gelatinous contents, the incision had to be enlarged and the growth turned out. In so doing, although it was handled most gently, the pedicle was torn across. Fortunately my custom of grasping this between two fingers during such manipulations enabled me to control the hæmorrhage that would have followed from the enormous vessels. There was but one adhesion, to the other ovary, in which similar changes were beginning. This was excised, too. A suspicious thickening of the parietal peritonæum was also found on the left side. After thorough douching, the abdomen was drained for twenty-four hours. Recovery was good, barring a troublesome bronchitis. She has since gained flesh, the cachexia has disappeared and now, at the end of nearly six months, there is not the slightest increase in the induration felt in the abdominal wall.

The hæmorrhage, had not the pedicle been under control, must have been terrific, and, if not immediately fatal, would have been

arrested with difficulty and might have seriously influenced the result. The question of malignancy and the peritoneal infiltration



Appearance of intestine after adhesions had been cut loose. A is the raw surface produced; B, the same turned in and the peritonæum united over it.

necessarily suggest recurrence, but so far there has been no sign of such a complication.

I have operated four times during the past year for intestinal obstruction (internal.) One of these cases will shortly be reported by the attending physician, Dr. G. Maxwell Christine.

(1) *Rectal Cancer; Complete Obstruction; Inguinal Colotomy.*

Mr. C., aged 40, was sent me in the spring of 1889 with the diagnosis of "bleeding piles." Examination showed an extensive rectal cancer, about three inches up the bowel, involving the bladder and the perirectal tissue on every side. Excision, after the method of Kraske-Hochenegg, was suggested, but not urged as it did not offer any prospect of success with such an extensive infiltration. A colotomy, however, was advised before exhaustion and obstruction had worn him out. But his family would listen to no interference until November, when the hæmorrhages and the progress of the disease having reduced him to a skeleton, complete obstruction had supervened. The abdomen was enormously distended, most markedly so in contrast with his general emaciation; stercoraceous vomiting, always so late in obstructions low down, had set in and nature, in her efforts to afford some relief, had found a vent into the bladder, through which and the urethra flatus and fæces escaped in considerable quantities. A very painful and offensive cystitis was thus added to his other sufferings. The patient being apparently almost moribund, cocaine was used locally and combined with a few whiffs of chloroform. Inguinal colotomy was then performed at the Camden Homœopathic Hospital, after the method of Maydl. The abdomen was opened by a vertical incision with its centre on a line with and two inches inside of the left anterior superior spine of the ileum. The sigmoid flexure was readily found and drawn out, bent until two parallel limbs were formed and held in this position by a couple of stitches. An artery clip was pushed through the meso-colon at the upper angle to suspend the loop on the abdomen and prevent its retraction. The peritonæum was sewed to the skin and then to the intestine and the line of suture covered with iodoform collodion to prevent infection of the abdominal cavity. The gut was then opened transversely with the thermo-cautery and an enormous quantity of fæces and flatus evacuated. Relief followed at once and persistent washing of the distal intestine and bladder

removed the rectal and vesical symptoms. Six days later the gut was completely divided with the thermo-cautery, without an anæsthetic and without pain, and the ends trimmed down and stitched to the skin. The distal end of the intestine was made to fill one-third and the proximal two-thirds of the opening. The artificial anus functionated well until the patient died, in about two weeks, of the general exhaustion due to the original disease.

This is the third case operated by the method of Maydl, and I must confess to a decided preference for inguinal colotomy over the lumbar incision, as well as for a procedure that will support the intestinal loop, preventing retraction and emphasizing the spur. The operation accomplished all that could have been expected; it was too late to look for prolonged life, but it gave the patient a few more days and a quiet, painless end.

(2) *Acute Obstruction from Flexion, due to adhesions of Meckel's Diverticulum; Abdominal Section.*

C. H., aged 13 years, operated for an old-school friend, August, 1890. A little over a week before a cow had stepped on the lower portion of the abdomen. Some pain followed and purgatives were freely administered at home; they operated slightly for a day. When seen by his physician, complete constipation had existed for three days and vomiting had supervened. Large injections were given without avail and, finally, on the sixth day of the obstruction, the parents consented to the operation. There was then projectile vomiting, the ejecta having a decidedly fæculent odor; marked prostration, with small, weak, rapid pulse, pallor and pinched expression; a much distended abdomen, which was generally sensitive and slightly dull low down on the right side; frequent attacks of colic, during which the intestinal loops could be distinctly seen through the abdominal wall. Section showed enormous distension of the small intestine, and, on allowing a few coils to roll out, a collapsed loop of ileum and the cæcum were found under the dull area. The cause of the obstruction was an acute flexion, due to a drawing back and twisting of the intestine by a diverticulum (Meckel's), a little over two inches long, attached to the spine. The adhesions, which were old, were divided and the peritonæum drawn together over the raw surface, turning in about one-third of the pouch. This was not excised as the intestinal lumen into which it opened was quite nar-

row, the surface opposite the broad mouth of the diverticulum projecting toward the latter. (See Fig. p. 139.) A longitudinal incision was made in the intestine above the obstruction and the contents emptied; besides liquid fæces there were hundreds of watermelon seeds. This opening was sutured by a running stitch of fine silk, forward and back, and the abdomen closed in the usual manner, without drainage. The bowels did not move until the second day, when an enema of glycerine and then a large one of water were followed by an enormous stool with complete relief of pain and distension. They were kept freely open for a few days, to fight adhesions or to have them form with the intestine in a position favorable to its permeability, and have since acted naturally. He has made an excellent recovery.

The youth and vitality of this lad were undoubted factors in his recovery, for the operation was done none too soon. It seems a pity that, in the vast majority of cases of intestinal obstruction, operative relief is left until the patient is practically moribund, but it is to be hoped that the profession will soon be able to educate the public, as they have gradually done in regard to hernial strangulations, to remove this most potent factor in the terrible mortality following what otherwise would be a generally successful operation. This diverticulum usually causes obstruction by forming a band under which a coil of intestine becomes strangulated. A posterior attachment to the spine and a resulting flexion are more unusual. Only the portion of the diverticulum bared of its peritonæum by dividing the adhesions was turned in to cover the raw surface, as the narrowing of the bowel lumen required this pouch to avoid what otherwise would have been a stricture. The immediate cause of the acute obstruction is a question; the adhesions binding the diverticulum to the spine were undoubtedly of long standing; there were no signs of a recent inflammatory action, so that the traumatism cannot be blamed. Probably the free purgation used by the family, in consequence of the abdominal pain and possible intestinal torpor, so increased the peristalsis or downward pressure as to exaggerate the existing flexion into a complete occlusion.

(3) *Obstruction from Volvulus of the Transverse Colon; Catarrhal Appendicitis; Chole-Cystitis; Abdominal Section:*

J. W., aged 50 years, operated for Dr. A. S. Mattson, of Moores-

town, N. J., July, 1890. Absolute constipation had existed for nine days, but he was not seen by Dr. Mattson until the day before the operation. There was a history of attacks of ileo-cæcal pain, and this region was very sensitive about McBurney's test spot for the attachment of the vermiform appendix. There was general abdominal tenderness and distension, and considerable epigastric pain, as is usually found in all obstructions. On analyzing this, however, the pain and the tenderness were located, not in the epigastrium, but on either side, in the right and left hypochondria. The skin was jaundiced and the urine loaded with bile. All food was vomited, together with a suspicious smelling fluid at times. The prostration varied, and, while the heart's action was weak and rapid all the time, there came periods of collapse during which the patient seemed to be dying. When operated the pulse could not be made out at the wrist, and the heart beats were over 140 per minute. The usual treatment, carefully carried out, had failed to relieve the obstruction. I hesitated whether to make a lateral or median incision, as there seemed to be a strong probability of the trouble arising in the region of the appendix. The tenderness in the hypochondria excited enough doubt to lead me to choose the latter. On opening the abdomen and turning aside the distended loops of small intestine, the appendix came into view, "erect" and pointing upward and to the left, without adhesions, but distended and its walls evidently thickened by inflammatory processes of considerable duration. The distended colon was followed up to the hepatic flexure, where a large cystic gall-bladder was found. This had been disguised by the meteorism. The intestine was still dilated and continued so almost to the splenic flexure, where a complete twist of a short loop of the transverse colon proved to be the cause of the obstruction. Below this the gut was collapsed. This was readily undone and the abdomen closed as usual. The condition of the patient did not seem to warrant meddling with the appendix or gall-bladder; in fact, all the manipulations were carried out with the greatest difficulty, as the anæsthetizer had been obliged to let up on the ether and resort to frequent hypodermic stimulation. The abdominal walls were, in consequence, very disagreeably tense. The patient for a time rallied well, passed flatus quite freely and had an enormous stool within an hour after the operation, but the heart failure recurred quite fre-

quently during the night, and he died the next day. The autopsy revealed a catarrhal appendicitis, with thickening; a gall-bladder containing about a pint of muco-pus and about forty gall-stones, one of which had lodged in the cystic duct; the obstruction was completely overcome.

It is not often one meets with such a combination of "excuses" for abdominal section: a gall-bladder to drain, an appendix to excise and, the urgent cause, a volvulus of the colon!

In this connection I would record a case belonging to what I have classed as "miscellaneous" abdominal sections (those done for suppurative processes about the uterus or cæcum, exploratory incisions, etc.). It is one out of the usual run of appendical abscesses or excisions, to which subject I intend to refer more fully in a future paper.

(4) *Perforative Appendicitis; Abscess covered by Intestine; Laparotomy:*

R. W., aged 12 years, operated for Dr. C. R. Norton, of this city, August, 1890, on at least the twelfth day of an attack of appendicitis. Dr. Norton, it should be stated, had first seen him on the preceding day. The symptoms were the usual ones: ileo-cæcal tenderness; drawing up of the right lower extremity with numbness and then pain running down the thigh; a large tumor above McBurney's line, increasing upwards; bowel resonance over this, and an indistinct sense of deep fluctuation; high temperature ($102\frac{4}{5}°$); rapid pulse (120), chills, etc. A vertical incision was made over the centre of the tumor through which the colon presented. The appendix ran up along the inner side of the cæcum, was much distended, and buried itself in a mass of protective adhesions, which shut off the abscess, behind and to the inner side of the large bowel, from the general abdominal cavity. The colon was allowed to bulge into the wound, which was left open, except at its upper and lower angles, and gauze packed in so as to protect the abdominal cavity in case of rupture and produce adhesions that would later accomplish the same purpose. A channel was thus kept open, alongside the bowel, down to the abscess. On the eighth day a diarrhœa set in, consisting of blood and pus, and, in one stool, the characteristic fæcal concretion found in these appendical abscesses. The temperature has come down gradually; the pulse improved at once; the stools have resumed their natural character;

the wound has healed by granulation and the boy promises to make a good recovery.

Here was a perityphlitic abscess over which intestine was made out, differing therein from those cases where the pus has more or less completely worked its way through the abdominal wall. With this outlet cut off it could find a vent, as in cases I have seen, either into the abdominal cavity, into the bowel, or into the loose connective tissue of the iliac fossa and push upward as far even as the thoracic cavity. Abdominal section insured an accurate diagnosis, permitted artificial evacuation of the abscess, if indicated, or, if the wound were left open, made this the point of least resistance, and thus favored a natural evacuation in this direction. It has been advised by some that, under the conditions found in this case, the abscess should be opened, cleaned out and drained. Feeling the intact intestinal coils on the one hand and Nature's protective adhesions on the other, it seemed to me to be tempting Providence to open up a stinking collection of pus in such a neighborhood. Instead, gauze was packed in to shut off the abdominal cavity and produce adhesions, and the abscess and the bowel allowed to bulge in this direction of the least resistance artificially produced. This naturally favored an evacuation externally, and, failing in this, for the same reason, an opening into the intestine. While the latter is not as desirable as would have been the former, it is infinitely preferable to rupture into the peritoneal cavity or into the connective tissue behind the colon. I am inclined to think that the pus would have found vent into the latter if left alone.

While not strictly belonging to abdominal surgery, the subject of hernia certainly comes within the sphere of intestinal surgery which has been referred to in this paper. Of nine herniotomies done during the past year, one case should, I think, be reported, as a supplement at least, to a communication presented by me to this Society a year ago.

Strangulated Right Oblique Inguinal Hernia; Resection of Gangrenous Intestine; Union End to End by Rubber Rings:

J. T., aged 65, operated for Dr. B. B. Gumpert, April, 1890. Strangulation had existed for forty-eight hours in an old, partially-reducible hernia; fæcal vomiting had supervened. The patient declined to go into the hospital, and the operation had to be done

in a small, stuffy room, on a low, soft bed. Five inches of the intestine were found to be gangrenous and resected, with about four inches more to insure getting healthy tissue. The ends were united over rings of rubber drainage tubing, as described in the paper referred to. (*Hahnemannian Monthly*, October, 1889.) Interrupted, fine silk sutures were placed between the united strands of catgut from the rings and a catgut suture run over all and up and down the divided mesentery. Owing to the very unfavorable surroundings and consequent faulty asepsis, the gut was suspended in the abdomen by means of a strip of iodoform gauze passed through the mesentery. The opening was packed with gauze and a large absorptive dressing applied. The patient rallied well, passed wind and fæces subsequently, while the highest temperature was 100°. On the third day the gauze strip was removed and the wound repacked. Some local pain followed and then, gradually, complete constipation, with distension and vomiting. Turpentine enemata and glycerine injections were of no avail; purgatives were rejected, and examination through the wound was negative. The rapidly supervening collapse precluded abdominal section, and the patient died on the fifth day. The autopsy revealed moderate adhesions about the hernial opening; no peritonitis elsewhere; great distension of the small intestine to three inches *below* the united ends, the point under which the strip of gauze had been passed, where an acute flexion was found. Below this the gut was collapsed. In spite of the tremendous strain on them from the distension, the united ends had held and were firmly adherent, with the rings in situ.

I report this case for two reasons:

1. In order to judge of a new procedure every case operated should be reported.

2. While the result was an unfavorable one, this method of uniting the divided ends of intestine was put to a most severe test, that of great intestinal distension, and stood it without giving way at any point.

There seems to be but little doubt that the flexion was produced on withdrawing the gauze, the sticky adhesions holding the intestine in its bent position. With better surroundings, age and general condition it would have been preferable to make a median in-

cision and suspend the intestine there, as is done by some German operators; with better surroundings, too, the gut could have been simply replaced and the hernial opening treated radically.

I should add that the case reported a year ago, in which twelve inches of intestine were resected and the ends united in the above manner, still continues to do well as regards bowel functions and general health. Some time since a small abscess formed in the cicatrix and a silk ligature (from the neck of the sac) was discharged. With this the hernia recurred, but is readily controlled by a truss. I naturally feel that with the experimental and clinical results obtained we are justified in giving this method a further trial.

DISCUSSION.

Dr. T. J. Gramm referred to the case of hysterectomy as one that particularly interested him. He reviewed the different methods of treating the stump, and considered its extra peritoneal treatment as unsurgical, on account of the sloughing that follows. The intra-peritoneal method was the more surgical. He described a case of intra-ligamentary cyst he had operated with a very successful result.

In answer to a question regarding the relative value of lumbar and inguinal colotomy, Dr. Van Lennep said that, in a certain number of cases, the descending colon, and in a smaller number the ascending colon, have a complete meso-colon, so that they cannot be reached through the connective tissue at all. Then the abdominal cavity has to be opened. In the lumbar operation we are hampered in our manipulations by the depth of the wound and the narrow space between the ribs and the ileum. It has happened in the experience of operators trying lumbo-colotomy not to find the colon at all. Some of them have even opened the duodenum by mistake. On the other hand, many of the younger English surgeons of note, many American, and most German operators advocate inguinal colotomy as the preferable operation. He himself had been surprised, in the case under discussion, at the ease with which the colon was recognized and drawn out. The patient was practically moribund at the time of operation. Therefore, cocaine was used locally with a few whiffs of chloroform. After the incision, the first loop presenting was the sigmoid flexure, which was readily recognized by its longitudinal fibres, sacculation and the appendices epiploicæ.

The great trouble with artificial ani, especially when they are to be permanent, is that we have more or less retraction of the spur, so that fæces not infrequently pass into the lower diseased portion. The idea advocated by Maydl prevents this, although the same object can be attained by passing a stitch through the abdominal walls and under the intestinal loop. The spur, however, is not so marked.

He agreed with Dr. Gramm, that the method of treating the stump by bringing it into the abdominal wound was not a surgical one, but it was by far the safest. The ideal one would be to ligate the uterine and ovarian arteries and make a complete extirpation of the uterus and ovaries, leaving nothing behind to slough. The method of treating the stump, to which Dr. Gramm referred as Kelly's, the speaker had done two years age. At the time he thought he was doing Schröeder's method.

The objection that he had to this plan is that there must necessarily be sloughing. After the elastic ligature is loosened, between every stitch blood will gush out, and interrupted sutures must be applied to arrest it. Necessarily, with these seventy-five or a hundred stitches, there must be some sloughing of tissue. He should never, under these circumstances, feel justified in dropping the stump back. Besides, the mortality statistics were strongly against it. Of the other cases, he desired to refer to that of appendical abscess. He did not think that the abscess should have been opened at once into an intact abdominal cavity, even had he been sure that it would empty into the bowel. As is well known these abscesses have a most horrible stench. Fallopian abscesses are not to be compared with them in the danger of infection. Even evacuation and thorough disinfection he did not consider would have been safe. In all of these cases, where the wound is left open, there is danger of subsequent hernia.

REPORT OF THE BUREAU OF OBSTETRICS.

"Monstrosity by Defect—Abdominal Walls and Diaphragm Absent," by Edwin H. Van Deusen, M.D.

"The Delivery of a Monstrosity," by C. Alvin Yocum, M.D.

"A Case of Puerperal Eclampsia Cured by Belladonna 2c," by Joseph M. Gerhart, M.D.

"A Difficult Case of Labor, Showing a Serious Defect in our Ordinary Obstetric Forceps," by W. J. Martin, M.D.

"Painless Parturition," by J. L. Ferson, M.D.

"A Mistake in Diagnosis," by J. C. Millen, M.D.

MONSTROSITY BY DEFECT—ABDOMINAL WALLS AND DIAPHRAGM ABSENT.

BY E. H. VAN DEUSEN, M.D., PHILADELPHIA.

[This paper is presented at the request of the Chairman of the Bureau, who saw the specimen when it was brought to the college for mounting.]

In May, C. M., æt. about 25 years, gave birth at term to her first baby. The presentation was left occipito-anterior, and the labor was not prolonged. No abnormality was suspected before the birth. As soon as the child was born it was discovered that the intestines were unconfined by any abdominal wall, and the heart could be seen beating on the left side below the ribs, which were bent upward at an acute angle. There was no trace of a diaphragm. The heart soon stopped beating, and the short cord was then cut. The placenta and membranes were delivered soon afterward, and the patient made a speedy recovery under the care of her physician, Dr. Josephine Van Deusen. The baby was presented to the writer, who took it to the Hahnemann College for proper preparation and mounting, and it can now be seen in the museum. Dr. R. B. Weaver, Demonstrator of Anatomy, made, with the writer, a careful examination, which revealed the following condition:

The head is elongated from vertex to base. The frontal bones are separate and distinct. The frontal region is high. The nose is bent to the left, and there is more development of the right side of the face than of the left. The right arm is perfect in form, motion and development. The left arm is well developed, but motion at the shoulder is interfered with by the sharp bending upward of the ribs on that side, and extension of the forearm is prevented apparently by contracture of the biceps. In fact, there is some contracture of all the flexor muscles, and especially on the left side.

Talipes equino-varus exists on the right side. On the inner malleolus there is a cutaneous development simulating a supernumerary toe. The thigh is flexed, with the right knee presenting to the occiput. It is fairly well developed, and from the centre of the well-rounded gluteal region opens the anus. An imperfectly-developed penis projects at a right angle from the inside of the right thigh. Hypospadias exists.

The left leg is not well developed, and is connected by means of a ball and socket joint to a very slender convex bone, bearing no resemblance to an innominate bone, and not connected by bony or fibrous union to any other part. The skin is reflected from the left thigh to the lumbar region, to the right thigh, and also a small band to the left dorsal region. There is no other connection with the body. It lies between the right leg and the back, and the heel touches the right shoulder. There is marked flexion at the knee.

There is an entire absence of abdominal walls. The intestines were probably held in position during intrauterine life by the parietal peritonæum, but it was torn away from its attachment except along the ribs, and in all probability this occurred at the close of the labor.

The diaphragm is absent, and the ribs on the left side are bent acutely upward at a line drawn from the ensiform cartilage to the angle of the scapula, and exposing the heart, which was observed to beat for a few moments after the birth. The right thoracic cavity is fairly well closed in, the pericardium is intact, and the heart normal. The pleura and peritonæum are continuous.

The liver is a large shapeless mass. There is no suspensory ligament, and the fissure presents upwards, backwards and to the right. The stomach is large, and from it runs a large gut resembling the

colon, and increasing in size to about the jejunum or further, and then it suddenly diminishes and continues uniform to the cæcum and appendix vermiformis. From the cæcum to the anus is about five inches, and this gut is smaller than any other portion. The whole of the intestine is joined to a mesentery common to all, and the rectum is firmly bound down.

The spleen is of the size and appearance of an unripe plum. The right testicle is in contact with the anterior part of the kidney. The left testicle could not be found.

The condition of the lumbar vertebræ could not be accurately ascertained without a dissection, and this was not considered advisable in view of the mutilation it would necessitate. A rotation of the lower part of the spinal axis of nearly 190°, and then a sharp backward bend, had occurred at some time during gestation. The exact time and the cause of the occurrence is, perhaps, impossible to decide.

The child was born extra-matrimony, and from the date of its conception (about July 24th) to November 10th, a period of three and a half months, the mother made every effort to conceal the fact. She frequently wrestled with her cousin, and was several times thrown to the floor with considerable violence, but on none of these occasions did she experience any unusual sensations.

On October 6th she travelled two hundred miles by rail. She had been vomiting at times before this. The journey was very fatiguing; her vomiting was violent in the extreme. In a few days she was better, and returned home on the 16th instant. On the 24th she experienced a fright, which affected her profoundly. She was sitting alone in the evening thinking of her trouble when there was a sudden report, and rattling as of shot against the window, and she thought some one had shot at her. It was only a handful of corn thrown with violence by a mischievous boy, but she was very much frightened, and speaks of it now with a shudder. Early in November she arrived in Philadelphia, after a hard journey of sixteen hours. She was again very much fatigued, and vomited violently for more than a hour.

For three months she suffered from a host of symptoms largely mental, although it was so uncomfortable for her to walk that she spent much of the time lying down. On February 23d there was

a gush of a quart or more of water with some pain. From this time until the date of the birth, May 1st, there was a more or less constant leakage, with an occasional gush of a quantity of fluid, and during the last month the discharge was frequently bloody.

The father of the child is said to be a well-formed and apparently healthy man. His mother, however, is said to have given birth to an imperfectly-developed or a malformed child, which lived only a few hours.

THE DELIVERY OF A MONSTROSITY.

BY C. ALVIN YOCUM, M.D., POTTSTOWN.

On the 20th of August, 1889, I was called to see Mrs. M——, æt. 32, who had given birth to three children. She informed me that she was pregnant and that she desired me to attend her during labor. She seemed to be very anxious about her condition, and appeared to think that she would be unfortunate during labor.

I observed that there was an enormous distension of the abdomen, and, judging from appearances, concluded that she might give birth to twins, or possibly triplets, or else there was an unusual quantity of the amniotic fluid. She complained of headache and dyspeptic symptoms, for which I prescribed the indicated remedy and left her. I saw her again in about a week, when she said she was feeling much better, but was still fearful that she would be unfortunate during labor. I gave her encouragement and assured her that I believed it would be all right.

About 11 o'clock P.M., on the 2d of September, I was hurriedly summoned by her husband, who informed me that his wife was in labor, and that my services were required immediately. On arriving at the bedside I made an examination and found that she was not in labor, for there was a small portion of the cervix uteri perceptible, and as the pains were very few, faint and not of an expulsive character, I concluded to go home, telling them to send for me so soon as the pains became stronger.

About five o'clock the next morning, I was awakened by the husband, who informed me that I should come as quickly as possible, for the womb, after-birth and everything else, with the exception of the child, had come away, as he expressed it. Thinking it must be an unusual case, I accordingly hastened, and on arriving on the scene found her in labor. An extensive discharge of the liquor amnii had taken place, but the womb and its contents were fortunately still intact. The pains were weak and far apart. The os was slightly dilated; the presentation was a face.

I had summoned a Homœopathic doctor on my way to the patient, and, after we had satisfied ourselves in regard to the presentation, we concluded to use a vectis and endeavor to change the presentation to that of a vertex. Having no vectis, I handed the blade of an Elliott forceps to the doctor who accompanied me, and to our surprise and satisfaction, by a little manipulation he succeeded apparently in bringing down the vertex, and a careful examination revealed a change in the presentation. The doctor then left me, saying he did not think there would be any further trouble. I had apprehended trouble from the beginning, and informed him that if I needed any assistance I would send for him.

About thirty minutes after his departure the pains returned, under the administration of secale 3x, and I discovered on making an examination that the presentation was again the same as in the beginning, and I noticed that as the pains came on the vertex became more and more firmly impacted in the right iliac fossa.

My first thought was to apply the forceps and deliver the child if possible, and in case I should fail in this I would then perform version; but I thought it prudent to have the presence and assistance of another doctor before I proceeded any further, and hastily summoned the physician who had been with me before. The messenger returned and said that the doctor refused to come, as he had some unimportant business out of town. I then immediately sent for the other Homœopathist who lived in the town, but the messenger also failed to find him. I now began to realize that I was all alone with what I regarded as a serious and difficult case of labor, for I seemed to think I would have trouble, notwithstanding the doctor's opinion that all was right after he had used the vectus and had only pushed the child up into the excessive quantity of liquor amnii (for

there was at least two or three gallons of this in the womb, which accounted for the unusual distension), and had not changed the presentation in the least, for this was an impossibility under the circumstances, as we shall see further on, for the first pain again brought the original presentation. Having found it impossible to procure the services of a Homœopathist, I concluded to do the next best thing and sent for a "regular," for the character of the husband was such as to render him entirely unfit to be of any service as far as any assistance was concerned.

It seemed that fate was against us, for the husband, whom I had sent to bring any doctor he might meet, did not return for a half-hour, so I summoned a lady in the neighborhood, with whom I was acquainted, to assist me, and proceeded to etherize the woman, in order that I might apply the forceps and deliver the child.

About the time the woman was well under the influence of ether, and I was about ready to apply the forceps, the husband returned, and, upon seeing what I was doing, became furious, snatched the cone out of my hands, threw it across the room, exclaiming, "None of that, doctor, I've seen enough of that, and won't allow it," and at the same time assumed a very aggressive and threatening attitude. I took in the situation in a moment, concluded it was my duty to deliver the woman as soon as possible, and knowing that "desperate cases require heroic treatment," without asking many questions hustled him out of the room, pushed him down stairs, and locked the door. I then gave a little more ether, and with great difficulty applied the forceps, especially the female blade, because of the vertex being so firmly impacted in the right iliac fossa. I made gentle traction at first, and by degrees used more force, when the forceps slipped off. After several futile attempts I abandoned the use of the forceps, and concluded next to perform version, but just at this juncture a "regular" put in his appearance.

I gave him a brief history of the case, and then asked him to make an examination. He did so, but failed to determine what part was presenting, or at least he did not seem inclined to give his opinion in regard to it. I then informed him that I considered it a face presentation. He made no reply, but apparently seemed to be very much excited. I asked him to apply the forceps and see what he could accomplish, cautioning him to be very careful how he in-

trodnced the female blade, as the head was very firmly impacted in the right iliac fossa. He paid no attention whatever to my advice, and, in attempting to introduce the female blade and finding so much resistance, he used such force as to produce a copious hæmorrhage, the hot, red blood streaming out as from a hydrant, when he gave her an immense dose of ergot and attempted to introduce the female blade again. I now interfered and told him such treatment would not do, but he seemed to be entirely oblivious to the fact that he was killing the woman, and I came to the conclusion then and there that, instead of a "regular," he was indeed a very "irregular obstetrician," and that the term "regular" as applied to practitioners of a certain school of medicine had a wide signification, and beside meaning the embodiment of all that is useful, scientific and curative in medical practice might also signify deplorable and inexcusable ignorance and cruelty. Finding that he was worse than no one at all, I asked him to stand by the bedside while I hurriedly drove away to bring another doctor whom I expected would be at home at that hour. I commanded him to leave the woman rest until I returned, but no sooner had I left the room than he commenced to use the forceps again in anything but a skilful manner, and when the doctor and myself returned in a few minutes we found the woman in a dying condition. We performed version after the last doctor had tried in vain to deliver with the forceps. We succeeded with great difficulty in bringing down both feet and delivering as far as the hips, but now came the greatest difficulty of all. The woman was in a dying condition from exhaustion and hæmorrhage, and the combined strength of three men was not sufficient to deliver the child. As a last resort we tied the legs together with a towel, and by continued and persistent manipulation and traction, we finally succeeded in delivering the child, and saw that the whole trouble was caused by deformity. The force we had exerted had broken the occipital bone, which probably accelerated the delivery. As soon as the child was delivered we administered stimulants, but all was of no consequence, as she died one hour after delivery, complaining of a severe pain in the epigastrium until death relieved her.

I will not describe the monstrosity very minutely, as the photograph which I will pass around will explain it much better. The only deformity was the absence of the cervical vertebræ, the occi-

pital bone resting on the lower portion of the dorsal vertebræ, being firmly fixed at about an angle of 60 degrees. The other portion of the body is normal, with the exception of the face, which has a beastly, unnatural appearance. The weight is probably from seven to nine pounds. The specimen has been placed in the museum of the Hahnemann Medical College.

I have often questioned to myself whether the proper treatment at the right time had been given to the woman, and whether it was possible under the circumstances to have saved her life. The deformity was undoubtedly the misleading part, and that which partly decided the fatal termination of the case, for had we discovered this in the beginning we might have performed craniotomy, and possibly have saved the life of the mother.

Many persons who have examined the photograph say that the child resembles a lion. The mother was frightened by a lion between the fourth and fifth months of pregnancy.

A CASE OF PUERPERAL ECLAMPSIA.

BY JOSEPH M. GERHART, PHILADELPHIA.

On October 7, 1889, at 12 o'clock, noon, I was called to see Mrs. B——, primipara, æt. 20 years, just one month previous to her expected confinement. She had eaten heavily, the night before, of indigestible food, consisting of fried oysters, sauces, cakes, etc. Since morning had been suffering from terrible headache, nausea and vomiting of bilious matter. I found her suffering from a terrible, bursting headache, with the face red and bloated, the pupils dilated, and constant nausea, brown coated tongue. I was in the house but a few minutes before she vomited a watery substance, which was followed by terrible retching. All at once, her head turned to the left side, with twitching of muscles of the face, followed by a general convulsion. I gave belladonna 30. She had been stupid all morning, and now lost consciousness. She had not complained of any labor pains, but, upon examining her, I found the os slightly dilated and patulous. The spasms occurred about every twenty minutes, and it appeared as though they accompanied every pain. Belladonna gave no relief. The face became quite purple, and she tried to get out of bed. There was twitching and jerking of muscles, and clenched thumbs. I gave hyoscyamus 30; no relief followed. During the afternoon, I gave several remedies without relief. At 5 P.M., the os was dilated to the size of a half-dollar, but very rigid. I now put her under gelsemium tincture, a few drops in half-glass of water, a teaspoonful every eight or ten minutes. The convulsions continued just the same.

By 6.30 P.M., the os was sufficiently dilated to permit of the application of the forceps, and I delivered her of a living boy.

The spasms continued every ten to fifteen minutes. For these symptoms I gave belladonna 2x for an hour without relief. At 7.30 P.M., I changed to hyoscyamus 3. I left the house at 8 P.M., and she was then somewhat easier. The spasms were not so violent, and occurred less frequently. When I returned, at 10 P.M., two hours later, I beheld a terrible picture. The spasms now occurred every ten minutes, and were very violent. She tried to jump out

of bed. Her face was fiery red, and bloated; the pupils dilated; the tongue dry (not a particle of moisture), and there was jerking of muscles, etc. I immediately dropped a few pellets of belladonna 200, dry, on the tongue, followed by placebo. In less than fifteen minutes she sank into a sleep, and slept until 11.30 P.M., when another spasm occurred, so violent that I did not think she could possibly live through it. I did not repeat the medicine until 12.15 A.M., when I again dropped a few pellets of belladonna 200 on the tongue. In fifteen minutes more she was easier; and by 1 A.M. she was asleep. That was the last spasm, and also the last dose of medicine for six days.

I left the house at 6 A.M. on the 8th, patient sleeping soundly, temperature 100°, and it never rose above that. At 12, noon, the patient was partially conscious; by evening she recognized her family.

October 9th.—Patient slept during the night, and now desired food, and was much pleased with her baby, and delighted to think she had been delivered without being conscious of any pain.

On the 10th, milk made its appearance, and the mother nursed her babe.

October 10th to 14th.—Steady improvement.

October 14th.—Had marked mercurial symptoms; she was thirsty; the tongue flabby and indented by the teeth, profuse perspiration, and scanty, red urine. I gave two doses of mercurius vivus 30, which completed the cure.

The urine contained albumen in abundance, but it all gradually disappeared; the percentage was not taken.

A CASE OF DIFFICULT LABOR, SHOWING A SERIOUS DEFECT IN THE ORDINARY OBSTETRIC FORCEPS.

BY W. J. MARTIN, M.D., PITTSBURGH.

DECEMBER 10, 1889, at midnight, I was called to Mrs. M. G., æt. 23 years, in labor with her first child. On examination I found the os dilated to about the size of a quarter dollar and patulous, the

head presenting. The pains were strong and quite regular. There was nothing in the case at this time to cause me to anticipate any trouble. The woman was young, very strong, and superbly developed; had always enjoyed good health—phenomenal good health for a woman in these days—as she informed me that she had never in her life taken a dose of any kind of medicine. She had suffered none of the usual complaints of pregnancy, and had worked hard during the entire period, doing all of her housework unassisted. She claimed to have gone some six weeks over her time. As to the correctness of this, or as to the possibility of it, I say nothing, but would like to hear something on this point from the members of the Society.

The night slowly wore away, and the woman slowly walked the floor, being unable to tolerate the pains when lying or sitting. At eight o'clock in the morning the os was fully dilated, and the head was at the superior strait, but it would not enter or pass through the strait. There seemed to be room enough, and there seemed to be pain enough, but the fœtal head was large and firm, and would not mould into the pelvic inlet. I now suggested chloroform and forceps, to which she did not make serious objection. So we placed her in the proper position, and completely anæsthetized her. The application of the forceps was not difficult (I used the Wallace-Hodge long forceps), but traction upon them with all the strength I possess failed to bring the child's head through the superior strait, but, instead, the forceps slipped off. My efforts were continued from eight to ten o'clock, when I was compelled, through sheer exhaustion, to give up. This I did with no little reluctance, as it was the first case that I had failed to deliver in the thirteen years that I have practiced, and I had harbored the belief that, with my Wallace-Hodge long forceps, I could deliver anything, provided I could get them on and locked. But in this case I was beaten; the forceps could be applied and locked, but the head was no nearer delivery after two hours of pulling on it than when I started; the only change in it was the large caput succedaneum produced by the slipping off of the forceps.

I now called to my assistance Dr. Z. T. Miller. Dr. Miller had a pair of long forceps (the name of them I do not know), with which he had never failed. These he sent for, but the result was the same

as with mine—they slipped off every time. We continued our combined efforts from 10 A.M. to 2 P.M., when we called Dr. C. P. Seip, who brought with him a pair of forceps quite different in shape and structure from ours. They were old and clumsy-looking. They had been made nearly half a century ago by a blacksmith, to the order of Dr. H. H. Hofmann, a respected member of this Society, and one of the oldest homœopathic practitioners in the State. These forceps, when carefully applied, did not slip, and slowly, very slowly, brought the head down. For two hours we three took turns, pulling with all our power upon these forceps before the head was delivered—a black and shapeless mass. Then it was a very difficult thing to get the body delivered, notwithstanding the fact that the perinæum was torn to the sphincter ani. The cause of all this trouble will be at once apparent to all when I tell you that the babe weighed twenty-one pounds and three ounces.

The incompetency of our forceps (Dr. Miller's and mine—and what I am about to say will, I believe, apply to nearly all forceps in use at the present day) consisted in the blades being too short; consequently they did not grasp enough of the head, and this is why they slipped. The length of the blades of the Wallace-Hodge forceps is six inches. From the lock to the beginning of the blades there is three inches of handle or shank, but this is unavailable on account of the two sides being in apposition, or nearly so. In the ancient-looking forceps of Dr. Hofmann the blades begin at the lock, thus allowing us to push them up over the head much farther than we could ours, and giving us a grasp upon it that would not slip. Without these instruments, or others of a similar kind, we would have been unable to complete this delivery without resorting to either embryotomy or Cæsarean section.

After it was all over, the opinion of all concerned was that it would have been better had forceps delivery never been attempted, but the Cæsarean section made at the first. This proves that hindsight is more correct than fore-sight. I did not know that the disproportion between the size of the fœtal head and the pelvic inlet was such as to practically prevent delivery by the natural channel. Perhaps a more thorough obstetrician would have discovered this, but how he would have done it is one of the things that I do not know.

The subsequent history of this case will be made brief. On the fortieth day after delivery the woman died. During all this time it was necessary to use the catheter to empty the bladder. For the first two days after her confinement she had no unusual symptoms. On the third day, when I entered the room I at once recognized the peculiar sweet, sickening odor of gangrene. Examination revealed the fact that the entire external genitalia were black, even back to the anus; also two dusky spots in each ischio-rectal space. I was struck with the horrible probability of this woman losing all the soft parts composing the floor of the pelvis. In addition to this and the retention of urine, she now had a dark, foul, watery diarrhœa. ℞. Arsenicum 3, a dose every two hours. In the evening, finding the gangrene progressing, I proceeded to combat it with the bromine treatment as recommended by Dr. Goldsmith, a medical director of volunteers in the United States army during our last war. (Dr. Goldsmith found that when wounds affected with hospital gangrene were thoroughly cauterized with bromine, not only was the disease arrested, but the dissemination of the vapors materially aided in preventing the spread of the disease to other patients. The gangrenous parts must be carefully trimmed away with scissors or scalpel, and the bromine applied directly to the surface. Many cases of failure were due to the fact that the application was made on the outside of impenetrable sloughs. The bromine may be applied by a stiff brush or a mop made of cotton or charpie. If there are pockets, the drug must be injected into them with a syringe. After this all odor ceases, the part shrinks, and healing goes on if, at the same time, the general health be attended to. The cauterization need not be repeated except at points where the disease seems not to have been reached. The solution recommended for use by Dr. Goldsmith is as follows: Bromine, 32 grammes; potassium bromidi, 10 grammes; aquæ destillati, 128 grammes. [See *Reference Handbook of the Medical Sciences*, vol. iii.]

In two days I found it necessary to repeat the treatment, the first not having been done thoroughly. This stopped the progress of the gangrene. Sloughing and suppuration were extensive. Symptoms of septic infection were very pronounced. In passing the catheter, there is reason to suppose that pus and septic matters were carried into the bladder, giving rise to a violent cystitis. Becoming un-

covered at night while sweating resulted in a bronchitis, with most violent cough. These, with poor nursing and a drunken, unsympathizing husband, were altogether a combination of unfavorable circumstances too much for the vital forces to withstand. The marvel is that she held out so long.

DISCUSSION.

Dr. W. G. Dietz said that he was called, some four or five years ago, to a case somewhat similar to that described by Dr. Martin. He was sent for early in the morning. Dilatation was very slow. He had delivered the patient, two or three years before, of a very large child, weighing thirteen pounds, with the Hodge forceps. After waiting some time, he attempted to make digital dilatation, and then he applied the Hodge forceps. He was aware, in the beginning, that he had to deal with a large head. As soon, however, as he made traction, the instruments slipped. He reapplied them twice with the same result. He then sent for assistance. An Allopathic physician responded, and applied the forceps three times, with the same result. It was then decided to perform version. The feet were brought down without much difficulty, and, after a long, hard tug, the patient was delivered of a child weighing seventeen and a half pounds. The forceps exhibited by Dr. Martin might have done good work in this case.

We are very apt to hope for the best when things are not all right, hoping that the case will turn out well, without making an effort to ascertain the exact condition of affairs. If, when we find that the head is as large as has been described in these cases, it would not be better to perform Cæsarean section, is a question. The great difficulty in the majority of these cases is that the operation cannot be performed under aseptic surroundings. Under such circumstances the speaker thought that rather than risk the patient to sepsis it would be better to perform version. While the life of the child is more liable to be lost, the mother has far better chances.

Dr. W. J. Martin said that he must differ entirely from the last speaker regarding the propriety of performing version in these cases, as by it the condition must certainly be made much worse than before.

Dr. T. J. Gramm suggested that the instruments exhibited by Dr.

Martin, and which he had found so useful, should be measured and drawn, that others like them could be made for general professional use. He thought that when delivery became so difficult as to require the exhibition of as much strength as had been spoken of at this meeting, it would be far safer to resort to Cæsarean section at once. Under the safeguards of to-day it is a comparatively safe operation.

Dr. H. K. Hoy approved of the ideas presented in Dr. Martin's paper, and reported a similar case.

Dr. C. P. Seip, in reply to a question by Dr. T. M. Johnson, said that the forceps in question were applied with remarkable ease; in fact, easier than any other instruments with which he was acquainted. When once they are applied, and traction is made, something is bound to come, for they have a grip that will not yield.

PAINLESS PARTURITION—TWO CASES.

BY JOHN L. FERSON, M.D., PITTSBURGH.

In the *Medical Advance*, volume 21, page 335, is an article on "Painless Parturition," which opened to me prospects of greatness in that line of practice, and led me forthwith to purchase the volume entitled, *Parturition without Pain*, of which it makes mention.

In my obstetrical practice I have always made it a rule to earnestly advise vigorous out-door exercise daily, right up to the time of labor; loose clothing, plain substantial diet, and regular hours of rest. But the article, and book mentioned, promised results far beyond anything ever thought of or expected, save in exceptional cases.

Shortly afterwards, two lady patients informed me very early in their pregnancy of their condition, and, inasmuch as they both expected to be delivered about the same time, I determined to give the plan advocated a trial. The plan is, in brief, the use through the entire period of gestation of such foods as shall not develop the bony structures of the fœtus, so that, when labor comes on, the bones may

be cartilaginous, soft, and pliable; easily conformed to the pelvic outlet of the mother, and escape with little effort or pain on her part. The food to be eaten should consist of ripe fruits, vegetables, sago, rice, tapioca, oatmeal, eggs, cheese, and flesh of fowls and young animals. No hard water is to be used, but free use made of acidulated drinks. Wheaten bread, pastry, salt, spices, and meats other than those mentioned above, were to be avoided.

The authorities quoted support their claims by such strong testimony, the recital of such satisfactory cases, that one cannot fail to respect and credit the recital. The question arises in one's mind: "Are these brilliant results invariable?"

Both my patients gave a ready assent to my plan, and the diet prescribed was steadily pursued till delivery. I am positive that not a half dozen times did they, in the slightest, deviate from the rules laid down.

Case 1.—Mrs. R——, æt. 23, had a miscarriage one year ago, at which time I did not attend her. Her previous health had been good, but labor was followed by subinvolution with menorrhagia, for which she came to me for treatment. Her uterine symptoms, consisting of dragging pains, aching in back and hips, and general weakness, persisted more or less through her pregnancy. Her desire for a living child and her dread of another miscarriage, were so great that it was difficult to induce her to take sufficient exercise, which I am sure would have had a good effect. Toward the end of gestation the general health improved, and she went out-doors considerably, and was bright and cheerful.

On December 10th, 1889, early in the morning, without a warning pain or any discoverable cause, the amniotic fluid began to escape in small quantities, and continued till late in the afternoon, though she had been kept quiet in a reclining position. In the evening, slight pains began, but did not become severe till midnight, when real labor began, and at 2.30 A.M. a girl baby, weighing about five pounds, was born. The labor was a very easy one, but not more so, or in fact, so easy as others I have seen. The child was well-formed, and appeared to have fairly good bony development. The fontanelles were large, and the cranial bones thin, and in labor they overlapped considerably, unquestionably making the extrusion of the head easy. The ease of the labor pleased me, and I was ready to vote

the plan a success. The child, however, was cyanotic, and only lived for a couple of weeks. The mother, although she grieved a great deal, got along nicely, and has had better health than at any time since her miscarriage.

Case 2.—Mrs. S——, æt. 27, primipara, of strong constitution and has always enjoyed good health. She passed through gestation in the most vigorous physical condition, having always a good appetite and digestion, taking plenty of out-door exercise till within two days of labor. She was bright and happy, the only disturbances of any kind being vulvar pruritus, which yielded nicely to apis 30x and 200. At times there was heaviness of the stomach after food and occasional nausea, which was always relieved by a strong lemonade. Lemons were used freely, two or three daily.

On the evening of December 26, 1889, I was summoned, and found her suffering intense preliminary pains in the back, the os being but slightly dilated. Shortly after, pains became very severe and continued to be so till labor was completed. The patient was put to bed at nine o'clock, the os was dilated fully at ten. From six o'clock in the evening when pain first began, it continued uninterruptedly till delivery at 2.30 A.M. Not a cessation except for three-quarters of an hour after full dilatation of the os, when chloroform was used, but the pains became so weak under its use that the cervix was scarcely distended, and after that time it was withheld and the patient told she would have to do without it.

The bladder and bowels were evacuated, and various positions tried, but the pains continued without effect till 2 A. M., with the head still presenting at the superior strait in the right occipito iliac anterior position. The forceps being applied, delivery was effected in half an hour. The child was a boy, weighed ten pounds, two ounces, and apparently a prize baby. The bones were hard and firm, the posterior fontanelle was closed and the anterior opening did not exceed a nickel five cent piece. Such bony development I never saw before. The child was also very firm of tissue and shapely. The mother's milk came on the third day, was plentiful and of good quality, but the baby began at once to fail in flesh, and soon the skin was hanging in loose folds. The child was always hungry, as much so after nursing as before, seeming never to be satisfied. The stools were always greenish, slimy and full of curds. In consequence of this

undigested condition of the stools, attacks of colic were frequent, sometimes beginning in the evening and continuing without intermission till 8 or 9 o'clock next morning, the child crying all the while, and the abdomen being enormously distended.

After three weeks the child was taken off the breast. Then followed a succession of foods, in the order named—Hubbel's, lactopreperata, oatmeal, and Imperial Granum. The last named was given for the last three weeks of the child's life, and seemed to agree; under it the appearance of the stools improved so much that the night before death, which occurred February 23, 1890, there was a passage which appeared to be fully digested. Three weeks before death the baby began to round out and I hoped he had begun to improve, but a few days served to develop fully general anasarca.

On the morning of the day of death he awoke screaming shrilly. I was called and found him sinking into coma, and in a few hours he died from effusion into the cavities of the brain.

Careful study over this case by myself and with skilful counsel failed utterly to procure any satisfactory results. Magnesia carbonica seemed to cause some improvement of the digestion, and apis mellifica of the dropsy. The feeding was never more frequent than three hours. Both parents were perfectly healthy.

The recital of these two cases by no means sounds the death-knell of "Painless Parturition," but certainly serves to show that the good results to the mother in labor are not uniform, that in spite of care in excluding bone-forming elements from the diet, and the use of bone dissolving acids in drink, there may be a full bony development.

A MISTAKE IN DIAGNOSIS.

BY J. C. MILLEN, M.D., PHILADELPHIA.

On October 18, 1887, I called on Mrs. W—— for the purpose of making a diagnosis. Pregnancy and an abdominal tumor were suspected.

The patient, aged 33, had been married seven years, had four children and three miscarriages. Her menstruation had been regu-

lar until last May, when it had ceased. Since that time she thought there had been a gradual, though slight, enlargement of the abdomen.

On questioning her, I found she had experienced no morning sickness, while in her previous pregnancies this symptom had been a distressing one. There were no changes in the breasts other than those we would have naturally in women who had borne children. She had felt no movements, and I found that the suspicion of pregnancy had been based entirely upon the absence of the menstrual flow.

Placing my ear to her abdomen, I made a very careful and thorough search for fœtal heart sounds, but found none. Inspection showed the enlargement of the abdomen to be due almost entirely to a large collection of fat in the abdominal walls.

A vaginal examination revealed an extensive, but incomplete, laceration of the perinæum, the vagina lax and the posterior wall prolapsed, the cervix enlarged, soft and flabby, and having a deep unilateral tear. The cervical canal was open, and the finger could be passed readily to the internal os. The uterus was slightly enlarged, movable, and completely retroverted.

Ballottement gave me negative results, and I had, as you may imagine, by this time thrown out of my mind any idea of the existence of pregnancy. As a former physician, a prominent Philadelphia gynæcologist, had told her that she had an ovarian tumor, I made a careful vaginal and bi-manual examination, but could detect nothing abnormal, save the slight enlargement of the uterus mentioned before.

I then told her that, in my opinion, she was not pregnant, nor had she any tumor, at least none large enough to be detected. Subsequent events proved this assertion to be too broad. Had I qualified the first part of my diagnosis, as I did the last, my feelings a week later would have been more comfortable.

As the woman had a number of nervous and hysterical symptoms I urged upon her the necessity of having the lacerations of the cervix and perinæum repaired, and, after pointing out to her the advantages to be gained by the operation, took my departure.

I heard no more from my patient until October 25th, seven days after the examination, when, about 9.30 P.M., I received a telegram calling me in haste to her home. On arriving, I was ushered into

her room, and must admit that the first glance at the woman had a rather chilling and startling effect upon me. I found her in the act of taking a long, deep breath. In another instant she had closed her mouth, and, bracing her feet against the foot of the bed, began to bear down and grunt in a manner that was hardly in accordance with my ideas of propriety in a woman whom I was *sure* was not pregnant.

I made an examination as quickly as possible, and found the cervix hard and firmly contracted. Projecting from the os I could feel a body about the size of a large walnut, round, smooth and quite firm, and resisting to slight pressure. I could detect elevations and depressions, giving the impression to the finger of a fœtal head, which subsequent events proved it to be.

Let us leave the woman for a few minutes and go back over the first examination, and see if we can point out where and how I fell into error.

First, the woman's sickness stopped in May. If the cessation had been caused by impregnation she would be between five and six months gone. Now we know the fœtal heart is heard as early as the fourth month. In this case no heart-sounds could be detected. Quickening takes place about four and a half months, but the woman had felt no movements. Ballottement can be performed by the fourth month, but with this method of examination I obtained negative results.

Kyestine, which is found in the urine by the third or fourth month, was not present. Again, the size and movability of the uterus were against a diagnosis of pregnancy so far advanced. The enlargement of the abdomen, I have already said, was due to an accumulation of fat. We can also account for the stoppage of the menses from the fact that the woman's health had been very poor for over a year, there being a decided tendency to tuberculosis.

We have said that in previous pregnancies she had suffered from marked nausea in the morning, but since the stoppage of the menses she had no trouble of this kind.

I think you will all agree with me in saying that the weight of evidence was against the woman's having been impregnated in May last; but, of course, that conclusion did not prove that she was not pregnant at the time of the examination; and this was the thought that struck me when I found her in labor.

I had been right in thinking she was not six months gone, and in my certainty of this had never once thought of her having become pregnant two or three months after her sickness stopped; and just there I committed an error that I heartily repented of afterwards, although it has given me a piece of experience I would never have learned in any other way.

We will return to the woman, and I may add that in about thirty minutes from the time I arrived, she was delivered of a fœtus, whose appearance corresponded with the tenth or twelfth week of fœtal life.

We have here positive proof that the woman was impregnated two or three months after her menses ceased.

The signs of her condition were so slight that I was led into giving a positive diagnosis when it should have been a provisional one. Had the woman come to me with a history of no menstruation for three months, and had I found the same softened os and slightly enlarged uterus, these conditions would have had a far different significance to me.

Another point of interest in the case, not concerning the diagnosis, but the miscarriage, was the retention of the placenta after the expulsion of the fœtus. I waited some time for the after-birth, but as there was a complete cessation of pains, I examined and found the uterus flabby, the os open, and hanging from the cervical canal a cord of membranes. I was about twisting this about my finger to make slight traction, when I was greeted by a gush of blood, and there followed the most profuse hæmorrhage I have ever seen. Traction on the cord proved that the placenta was firmly adherent.

I, therefore, ceased all efforts at traction, and passed two fingers into the uterus in a search for the seat of placenta. I found the cavity filled with hard clots, some of which were covered with the membranes, and so resembled pieces of placenta that I was deceived and thought they were such.

The hæmorrhage had now become so alarming that I thought it best to get the uterus to contract if it would. I gave ℥j. fluid extract ergot, and made gentle manipulation over the fundus; and this, in a short time, brought on pains, and the uterus contracted down firm and hard. An examination of the discharges, and especially the hard lumps covered with membranes, proved to my mind

that the placenta was still in utero, and, as my patient lived a long distance from the office, it caused me considerable anxiety, but I did not think I was justified, under the circumstances, in going into the uterus again after it. So, after waiting an hour to see that all went well, I left my patient for the night.

The next day, on examining, I found a small shred of membrane hanging from the internal os. This confirmed my belief that the placenta was retained, and as there were no pains and apparently no effort on the part of nature to throw it out, I decided that the time for interference on my part had come. Passing my hand into the vagina, and inserting one finger into the uterus, I could feel a rounded, nodular mass about the fundus and a little to the left. I hesitated before deciding that this was the placenta, as it felt so very much like an inverted fundus roughened from the attachment of the placenta. Inserting my finger at the lower border, I endeavored to peel off the mass, and was, in a little time, enabled to extract a placenta about three inches in diameter, perfect and complete. The uterus then contracted down firmly, and the case has progressed well.

This paper is presented, gentlemen, not because the case related is in any way very unusual, but rather to point out the many errors into which I was led, with the hope that they may, in some degree, be a guide to others placed in similar circumstances.

REPORT OF THE BUREAU OF GYNÆCOLOGY.

"The Value of Remedies in Pelvic Diseases Before Resorting to Surgery," by Sarah J. Coe, M.D.

"Clinical Cases," by Millie J. Chapman, M.D.

"Three Cases of Abdominal Section," by C. H. Hofmann, M.D.

"What Medicine will do for Fibroids and Kindred Abnormal Growths," by Mary J. Branson, M.D.

THE VALUE OF REMEDIES IN PELVIC DISEASES BEFORE RESORTING TO SURGERY.

BY SARAH J. COE, M.D., WILKESBARRE.

In the present general knowledge of medicine, is it best to rely upon the indicated remedy for the cure of pelvic diseases and acci-

dents when surgery will do the work in less time and with an approximate expense to the patient?

In the rush and push of business pressure, are we not drifting away rapidly from the hard study and clear discrimination which is required to successfully treat and cure diseases medicinally when we resort immediately to surgical means for a cure, knowing that a knowledge of general surgical principles is all that is required?

Are we justified in taking the slower process of cure when the surgical means are at hand?

My reply would be, we are, after plainly stating the case to the patient. If it seems to be one curable by the use of remedies, is it not our duty as Homœopathists to try medicinal measures first?

In comparison of the two methods, do we not secure to the patient a better and more permanent result generally by medicine than by surgery?

When we consider the class of patients carrying pelvic disorders, we find them largely with the nervous element predominating, naturally or caused by disease, and to such the word *operation* is a formidable affair, and carries with it a shock to the nervous centres. Many times we get the reply, I prefer the slower process rather than take the risk of life or death by operation.

In those especially of a nervous diathesis, the resulting effect upon the mind is an important factor. When remedies are used the patients feel the curative processes at work in their systems, and, coming into the presence of the medical adviser, are assured, from time to time, that they are better and the medicines are doing all one could expect.

In the early and middle stages of ovarian difficulties, we believe many, if not all, the cases may be cured better by the use of remedies than by operation.

Many cases of dysmenorrhœa may be cured by remedies and mental influence where an operation with the dilator is now resorted to as the only means.

Possibly, when the practical importance of mental influences becomes more generally recognized, physicians will be obliged to acknowledge that psychology is as important as physiology.

From ancient times mental influence has been used, and many diseases can be cured or relieved merely by making the patients believe

they will soon be better, and by firmly implanting this conviction in their minds.

The present interest in hypnotism depends chiefly upon its therapeutic value, and suggestion is the chief agent in it.

Mental influence, added to a well-selected remedy, may be an important agent in the treatment of all kinds of pelvic pain with neurosis as its base.

My attention has recently been called to the frequent occurrence of neoplasms of the urethra and rectum, very inviting cases to a surgical eye.

The most common and the most interesting form which I have met has been the *papillary polypoid angioma.*

Here I have found bunches of dilated capillaries set in a moderately dense stroma of connective tissue, and covered with mucous membrane, that had the usual pavement epithelium.

They have varied in size from a pin-head to a hickory-nut, and have been usually single.

The text-books describe them under the name of urethral caruncle or vascular tumor of the urethra.

As a rule, they bleed easily on touch, and these were exceedingly sensitive.

The patients have carried one of them for a long period without suspecting anything more than a slightly irritable condition of the urethra. When, however, the tumor became large, the urine was obstructed, and severe pain was caused by the act of micturition. These tumors, by constant moisture and friction, had become eroded on their surface, and the ulcerations had given rise to hæmorrhage.

The cases usually were found in those with a lax condition of the urethral tissues and a tendency to a varicose condition of the parts.

One of my earliest cases of irritable caruncle, Miss S., a clerk, presented a congested condition of the urethra, with the neoplasm extending nearly around the meatus, plus a varicose condition of the rectum—as I now see, a clear case for the administration of hamamelis; but as my text-books recommended extirpation, I applied cocaine and excised by the scissors. The case was slow in recovering, although remedies were given for the general condition.

Several recent cases of polypoid angioma have been treated entirely with remedies with flattering and rapid success.

Miss O., several years past the climacteric, was suffering from anæmia caused by loss of blood. She complained of sharp pains, at times lancinating, not only in the urethra but also in the back, hips, supra-pubic region and thighs.

China was given with some success, but to hamamelis, locally and internally, belongs the cure.

Examination revealed a bright red tumor, the size of a hickory-nut, extending around the meatus, nearly obstructing the urine, with the urethra dilated and pouching behind the tumor. From the posterior lip of the cervix uteri hung a fibro-cystic polypus.

The year previous, during an attack of diarrhœa, she had given the symptom of bloody urine. It was a case very inviting to a surgeon, but, wishing to test the effect of remedies alone, hamamelis, fluid extract, was applied, on absorbent cotton, to the angioma every night, while hamamelis, 1x to 3x, was given internally every three hours. The hæmorrhage ceased, and decrease in size commenced at once and continued rapidly, no trace being left in three weeks.

Mrs. H., age 63, did not feel well; tired out; had erosion of labia with fissure at superior raphe, with violent pruritis. Examination revealed a bright red tumor, the size of a cherry, in a stage of ulceration, at the posterior portion of the meatus urinæ.

Sulphur 200x cured the pruritis. After this, hamamelis, fluid extract, was applied to the tumor and no medicine given internally. Decrease *rapid* and entire.

Recent cases of polypoid angioma of the rectum have not yielded to medicinal treatment as readily as those in the urethra.

Miss F. timidly announced that she had bleeding piles. Possibly I could tell her what to do. I gave some general directions, and, as her timidity gave way, she allowed me to examine the rectum, where I found a papilloma, just above the external sphincter, on the anterior portion, bright red in color, surface in an ulcerating condition, giving an irregularity of feel suggestive of cancer.

The pedicle was about one-half the size of the tumor. After an evacuation this always protruded partially, and if not replaced caused pain and bleeding. Hamamelis was used in this case with good results, although slow, as owing to the position of the tumor, the

medicine was difficult to apply. In two months it was entirely removed. With this case was retroversion and prolapse of the uterus.

Mrs. J., passed the climacteric many years, had never had any local difficulty, but was not well following la grippe; could not stand long or walk any distance without great weariness, and had bleeding piles, as she said.

Examination showed both cystocele and rectocele, with prolapse of uterus, and cervix in a seemingly carcinomatous condition. At the anus, a papillomatous angioma presented, irregular to the touch, easily bleeding.

Suppositories of hamamelis were used for this angioma after replacement until the uterine condition was better, when hamamelis, fluid extract, was applied with good but slow results.

To treat pelvic diseases with medicine unaided by surgery requires careful discrimination, more of the time and patience of the physician, with as good, if not better, results to the patient.

DISCUSSION.

Dr. Millie J. Chapman, said that she had had cases similar to those of Dr. Coe, but that she had been obliged to call in the services of the surgeon. She was glad to learn that some one had been able to cure them with medicines, and she should certainly try the treatment recommended.

CLINICAL CASES.

BY MILLIE J. CHAPMAN, M.D., PITTSBURGH.

Case 1.—*Premature Menopause.*—Mrs. R., when married was twenty-three years of age. At the end of one year gave birth to a child. Eleven months after the birth she menstruated naturally and again, ten months after that, being nearly twenty-six. Since that period, now fifteen years, there has been no appearance nor symptoms of the monthly flow. For a time she had leucorrhœa and a burning pain in the back. There is no congestion, erosion or displacement of the uterus. The cervical canal readily admits the

sound or probe and has from the first. There has been no ill-health that could be attributed to the cessation of the flow. The vaginal portion of the uterus has atrophied, but there are no contractions or senile conditions of the vagina.

Case 2.—Miss S. first menstruated at twelve years, was regular until twenty, when the flow returned too often. She had hard work and long hours. Her employment was changed and medical aid summoned, but the periods still anticipated a few days the full month. At thirty the discharge was excessive but only appeared every three to six months for three years, then went ten or twelve months a few times, but after the thirty-fifth year did not return.

She has had the changes in the system common at the menopause, flashes of heat, dizziness, and nervous disturbances. Also additional adipose, considerably increasing her weight. There was nothing in the family history to correspond with this early change. A sister menstruated until forty-eight and her mother until forty-nine.

Bomer considers either the premature or delayed appearance of the menopause due to some pathological cause, but in neither of these cases is there any disease manifest. This case and many others have received marked benefit from the following remedies for the disturbance of the circulation.

Lachesis.—When the flashes of heat are followed by coldness.

Sulphur.—If the heat was succeeded by profuse pespiration.

Actæa race.—Besides the flashes of heat, mental depression like a cloud settles down over the patient. Distressed, anxious fears without apparent cause.

Of course there are always other symptoms, but these are prominent.

During this critical period, persons of large flabby tissue, who perspire freely and have a cold skin, are benefited by wearing wool gauze from wrist to ankle in summer, and in the cooler seasons, heavier wool underwear. It assists in securing better circulation and prevents the internal congestions so often witnessed.

Case 3.—*Dysmenorrhœa Complicated.*—Miss L., applied for treatment for dysmenorrhœa, saying she had exhausted the skill of her regular attendant. She described the pains as spasmodic cramps. They occurred formerly only at the month, but now were almost constant. Had lost greatly in flesh notwithstanding she had a

ravenous appetite. Also a raw soreness about the umbilicus caused much suffering. This suggested to me some intestinal irritation and upon investigation found that segments of tænia were often discharged. Having some previous experience in studying symptoms and using various potencies to correct the unhealthful state which nourished parasites, I decided to begin by an effort to dislodge and expel if possible the "foreigner." A fast of twelve hours was followed by a two-dram dose of kameela and a mild purgative. This produced the desired result, a tænia so long that the interested party could have no ambition to see greater development was wholly removed.

Then I found there was prolapsus of the uterus—conical cervix, pinhole os, through which exuded an albuminous leucorrhœa. The suffering during the entire flow was extremely acute. Besides the umbilical irritation, there were other skin symptoms coming under silicia. She received that remedy in the thirtieth once daily for one month. Then magnesia phosphoricum in hot water during the acute pain of the period. Silicia 30 daily again, alternate weeks another month, then the magnesia phosphoricum, when she seemed well, but keeps a supply of the powders to use if needed, but has passed several months without pain.

DISCUSSION.

Dr. Martin had used similar treatments. In one case he used oil of turpentine. The patient fasted twenty-four hours, then took two ounces of the oil of turpentine, which had been thoroughly beaten up with the white of an egg. After that, he took a dose of castor oil. The treatment was successful.

Dr. B. F. Betts thought that the use of turpentine would be attended with danger in some cases. He had used filix mas, and had followed it with a small dose of turpentine, and had obtained most excellent results.

Dr. Martin said that the large dose of turpentine he had mentioned produced quite a warmth in the stomach, but no other deleterious results.

Dr. Sarah J. Coe said that she had had a successful case in a gentleman. She first put him on kousso, giving him two ounces of the drug. This was followed by the discharge of about twenty-seven

feet of worm. After that, she gave him another two ounces, and another long piece of worm was expelled. She then used pelletereine, which effected a permanent cure.

Dr. W. G. Dietz called attention to ground pumpkin seed as a remedy for tape-worm. He said that it was a very popular domestic remedy. The patient should take about six or eight ounces of the ground seed, which would be followed by the expulsion of the worm.

Dr. C. P. Seip said that he had a case in which the patient was discharging pieces of mucous membrane of the bowels under the supposition that they were portions of tape-worm. He had been under the care of another practitioner who was giving him turpentine. Urinary symptoms of that drug were also present. The turpentine was discontinued. Then the dysuria disappeared. In the course of a month the discharge of shreds of mucous membrane ceased, and the patient was entirely well.

Dr. E. S. Sharpless said that he had treated a number of cases of tape-worm with filix mas and rottleræ. He had also used pelletereine successfully.

Dr. W. G. Dietz called attention to the fact that a recent writer in the *Therapeutic Gazette* had recommended chloroform in large dose as a remedy for the expulsion of tape-worm. He, himself, knew nothing about this remedy from personal experience, and merely mentioned it as a matter of curiosity, and to learn if any others had used it.

Dr. J. S. Boyd said that one reason why many remedies fail to expel the tape-worm is that the parasite as it lies in the intestines is covered with mucus, which protects it from the poisonous effects of the drug. Now, if a purge is administered before the parasiticide is given, a successful result will be obtained.

THREE CASES OF ABDOMINAL SECTION.

BY C. H. HOFMANN, M.D., PITTSBURGH.

The cases here reported occurred during my service at the Pittsburgh Homœopathic Hospital, and with the exception of wash-

ing the abdomen with bichloride solution and disinfecting the towels and instruments, no antiseptics were used.

Case 1.—Mary C——, æt. 19, white, servant, entered the hospital June 27, 1889. Some time previous she had noticed a swelling in the abdomen. This was small at first, but gradually increased until, at the time of the examination, she looked as if she were seven months pregnant. The tumor moved somewhat with the uterus. No metrorrhagia had been noticed at any time. Fluctuation was distinctly felt by several physicians present. The pressure symptoms were becoming unbearable, and unfitted her for her duties as a servant. A diagnosis of fibro-cystic tumor was made.

On July 2d she was operated.

The abdomen was carefully cleansed and washed with bichloride solution. The usual incision was made, but it became necessary to enlarge the opening to get the tumor out of the abdomen until, finally, the incision was eleven inches long. The pedicle formed by the cervix and broad ligaments was from seven to eight inches broad, and was tied (using double strands of silk) at the cervix. The pedicle was then cut, seared with the actual cautery and dropped, and the wound closed with deep silk-worm gut and superficial silk sutures. A glass drainage-tube was introduced down to Douglas' cul-de-sac, and irrigation with boiled water ordered every four hours. For the first few irrigations about three drachms of blood were withdrawn, but by the second day the fluid was clear and amber-colored.

During the first three or four days there was persistent vomiting of all food and drink, with thirst, for which arsenicum was given without relief. Phosphorus was then prescribed, with almost immediate benefit. The sutures were removed July 10th and the patient discharged August 10th, nothing noteworthy having occurred during that time.

Case 2.—Margaret B——, æt. 56, married. This patient was sent to me by Dr. Stevens, of Wilkinsburg. She had an enormously distended abdomen, and had been advised by her family physician in New York city, where she lived until recently, not to consent to an operation. For several years she could not lie down, and had to sleep in almost a sitting posture.

On September 24, 1889, the operation took place. On opening

the abdomen a tumor was found closely adherent to the abdominal walls, so much so that the peritonæum could not be well made out, and the tumor was punctured. The escape of some of the fluid allowed the separation of the tumor, so that a start could be made. It was finally peeled and seared off, the incision being enlarged to the ensiform cartilage meanwhile. The posterior half of the tumor was not adherent. Nine gallons of fluid were caught and about a gallon was spilled. The sac weighed three pounds, so that the weight of the tumor can be safely placed at eighty pounds at the least. The pedicle was tied, cut and dropped. On account of the adhesions, a glass drainage-tube was introduced and irrigation made with boiled water. The stitches were removed September 30th, and the patient discharged October 15th.

There was so much redundant abdominal tissue that the skin lapped over extensively, and she suffered a good deal from an eczema which had formed in these folds. The condition was removed by dusting with corn starch.

Case 3.—H. M. C., æt. 49, married, was admitted to hospital September 25, 1889. She had for some years previously noticed an enlargement of the abdomen, which had gradully grown larger. She was in bad physical condition and going down hill rapidly, and she wanted an operation as a last resort. The tumor was nodulated and not readily movable. The diagnosis was reserved.

She was operated September 26, 1889. On entering the abdomen the most formidable complication presented that it has been my misfortune to meet. The omentum was adherent, and great numbers of bloodvessels extended from it to the tumor. They were about one line in diameter on the average. My impulse was to close the abdomen without further delay, but, on a short consultation with the physicians present, it was decided to give the patient a chance for recovery. Throughout the anterior aspect of the tumor it was necessary to ligate *en masse* and cut between. This made the operation exceedingly tedious. The posterior half of the tumor was also adherent, and it had to be pulled and seared off. Even in the pelvis the adhesions were extensive. The tumor was a multilocular cyst. The patient did not rally, and died soon after the operation.

On reviewing this case, I do not think I should ever again consent to take such large risks, with such formidable complications, in an enfeebled patient.

WHAT MEDICINE WILL DO FOR FIBROIDS AND KINDRED ABNORMAL GROWTHS.

BY MARY J. BRANSON, M.D., PHILADELPHIA.

In taking up the above subject for a paper, it is with full recognition of the fact that it is a very unpopular one in this age of surgical achievements; therefore, it shall have the one virtue of brevity. The wonderful skill attained in the surgical treatment of fibroids is well known, and needs no eulogist. While proudly admitting these facts, are we fully aware of what medicine will accomplish? And are we sufficiently patient to await the action of remedies?

Tumors are considered to be normal tissue in abnormal position. With this definition in mind, one can believe that it is a disturbance in the *dynamic* forces of the body which causes this abnormal disposition of healthy tissue, and a *similar dynamic* force will neutralize this process, and nature, always kind, will resume its healthy action. This sounds purely theoretical and not practical, some one will say, and *truly*, it appears, for we must admit there *is* a practical side to every question. For instance, if a fibroid tumor has assumed such dimensions as to cause violent mechanical suffering, or perhaps to threaten life, it is impossible to wait for the action of remedies alone. They will (if the similar is found) arrest the morbid action, but life is not long enough to wait for absorption or atrophy to occur, or the patient might succumb from mechanical suffering in the meantime or from exhaustion. In these cases the knife is required, depending on remedies to prevent a return of the trouble. Often, too, patients cannot be prevailed upon to await the action of remedies with the dread of an increase of the growth constantly before them, and insist on the knife lest delay might make the operation more perilous. Another thought has often come before me, and that is whether an operation is truly successful because the patient recovers from its effect; or is it not better to count *that* only success where the patient is not only freed from the offending member, but is also relieved from all the suffering caused by the tumor and by the condition of system which caused the growth? What has an operation which

only removes the *product* of disease to do with the cure of the cause of that deposit? Must not something be done to produce a condition of system which will not create this tendency to morbid growths? We cannot cut out a constitutional taint, no matter what its manifestations, but we may be able to neutralize this weakness by the truly selected remedy.

Then, again, in many cases a year is required, or even two years, before the absolute success of an operation is truly proven and all suffering relieved. If such is the case, this one or two years would give a length of time for remedies to have acted; neither can we always say that the knife is more speedy in its action when so long a time is consumed before its efficacy is tested. And the patient has the additional shock which an operation always is (more or less) to the nervous system. It is hard for the able surgeon to appreciate quite the terror which the word "operation" generally suggests to the patient and even to the entire family. One trouble in trying medicine is the fact that the more favorable time for surgical interference generally conceded is early in the trouble, just at the time when medicines are indicated. As recently as fifteen years ago an ovarian operation was only undertaken when a patient's life was in jeopardy; *now*, the tumor is no sooner discovered than it is removed. It is hard to believe that there would be any risk in judicious waiting if the patient is under the direct supervision of her physician, who can note any change, and at the least retrograde progress can, in all good time, resort to more active measures.

In glancing hastily over my books I find, out of thirty-five cases of fibroids, only four have been operated upon. Two with prompt relief of all the symptoms; two recovered after a year of varied discomforts; six patients have remained stationary; seventeen so much improved as to insist no further medicine was necessary, though still under casual observation; eight are perfectly well.

A few words about three or four of the cases:

Mrs. B——, married two years, one child. Two years before marriage had a large fibroid of the uterus (intra-mural). Had also hæmorrhage from lungs. Under steady medication she became perfectly well, married, and gave birth to one child; labor perfectly natural.

Mrs. P——, diagnosis of ovarian tumor ten years ago, and opera-

tion recommended. She did not consent, and for several years the tumor has been entirely dispersed; no medicine administered for past year.

Miss B—— is extremely interesting. The patient is 49 years of age, has a large fibrous growth matting together uterus and ovary, and packing the pelvis solid with diseased structure. Each month an exhaustive hæmorrhage occurred. Under the indicated remedy, oftener arsenic iodide than any other, the hæmorrhage has ceased, and the pain has so far diminished as to enable her to do all the work in a good-sized house in a family of three, and the tumor is somewhat diminished in size.

Mrs. C——, æt. 50, has had uterine fibroid for three years. She was under treatment for sufferings attendant on the menopause. For three months there has not been any trace of the fibroid, and she is in perfect health.

Mrs. G——, æt. 65, solid tumor of right ovary. She was extremely anxious for an operation, but three excellent surgeons refused it. Her suffering was from frequent irregular hæmorrhages and attacks of ovarian pain. Under millefolium the pains have entirely ceased, and it is now two months since she has had any hæmorrhage.

Miss A——, æt. about 60, came to my office suffering from heavy dragging in abdomen; jerking in limbs and feet; uterine fibroid the size of a cobblestone and almost as hard; a wen on head; fatty tumor on left shoulder the size of a fist. Under conium she has no suffering at all. The tumor is soft and elastic, and she forgets all about its existence.

Miss K——, five years ago, was alarmed by profuse menstruation. It amounted to alarming hæmorrhage at every menstrual epoch. A large fibroid was discovered the size of the uterus at the seventh month of pregnancy. The lower portion was crowded into the pelvis and caused great discomfort. Her appearance was ghastly, greenish pallor and colorless lips; no emaciation; excessive nausea when the hæmorrhage occurred. Ipecacuanha moderated the flow, but its action soon ceased. Under millefolium the hæmorrhage is entirely controlled, so the periods are natural. The pain has ceased, nausea does not occur, complexion nearly natural, and she follows her usual mode of life.

Mrs. E——, suffering from a hard, intra-mural fibroid of the posterior wall. The hæmorrhage every month kept the patient in bed for ten days or two weeks. The loss of blood was alarming, with fainting, ringing in ears, dimness of vision. A consultation was called, and the enlargement was considered malignant or very suspicious in its appearance. September, 1889, millefolium controlled the hæmorrhage and all the symptoms, and she has not needed to lie in bed for the period since that date. The fibroid has softened, and she only calls once in two or three months to say how well she is.

DISCUSSION.

Dr. T. J. Gramm said that the peculiar genius of the homœopathic belief was such that men become somewhat modest, and ascribe their failures to their own errors in prescription, so that they are tempted to try one remedy after the failure of another. Now, he thought that this tendency to confine oneself to the use of remedies should be limited. The fear of operation is in the minds of the laity and in that of the physician also. It was his fortune to see cases that should have been operated upon early advance to a condition when they could derive no aid from the knife.

Dr. B. F. Betts said that there was no question more serious to the physician than that relating to the propriety of performing major operations. The conscientious physician will always hesitate before he decides this important question. There was one rule which seemed to him to be always good, and that was to operate when the patient was in the best possible condition. If there is no chance of the patient improving under medicinal treatment, then the operation should be performed without delay. Until we have made the effort to improve the patient's condition by medicinal treatment, we do not know that the time has arrived when the operation should be performed. We do not really lose ground trying to improve the patient's condition by Homœopathic treatment. The time for operation of an ovarian cyst is the earliest time possible after it has become of good size and the patient's condition is favorable. After they have developed, we cannot hope to cure them with remedies, though we may sometimes reach them in their incipiency. He did not think that we were obliged to always select a remedy known to exert an action

on the pelvic tissues directly, prominently or especially. These pelvic diseases so often affect the nervous system of the female that we have thus given us indications by which remedies may be selected. We are thus driven to the necessity of prescribing according to the totality of the symptoms, and not for the pelvic symptoms alone. The mental symptoms themselves are often of paramount importance.

THE REPORT OF THE BUREAU OF OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

"An Enigmatical Case," by W. H. Bigler, M.D.
"Aural Practice," by H. K. Hoy, M.D.
"The Eye in Relation to General Diseases," by W. W. Speakman, M.D.
"Three Cases of Glaucoma," by J. C. Morgan, M.D.
"Laryngeal Tuberculosis," by I. G. Shallcross, M.D.
"An Onosmodium Case," by H. F. Ivins, M.D.
"Points on Local Treatment," by R. W. McClelland, M.D.

In the absence of the Chairman of the Bureau, Dr. R. W. McClelland, H. K. Hoy, M.D., acted as Chairman.

AN ENIGMATICAL CASE.

BY W. H. BIGLER, M.D., PHILADELPHIA.

The verification of a diagnosis by a post-mortem examination doubtless gives to many physicians satisfaction, but little, if any, inferior to that experienced after the cure of a case with doubtful diagnosis. Correspondingly depressing is it to the scientific mind to have his diagnosis and prognosis both utterly overthrown by the results of his treatment; to have a patient recover who *lege artis* should have died, or one to have escaped nearly unscathed, to whom something dreadful should have happened. We, as Homœopaths, owing to the peculiarity of our practice, must be content to have

such things occur, and must try to see, with equanimity, incurable cases get well and patients obstinately refuse to grant us post-mortems for the sake of science. On the other hand, however, something can be said in defence of a cure under any circumstances. There is some satisfaction in it, especially for the patient, even if it is in spite of our diagnostic skill. The patient cannot be supposed to have an interest in the advance of medical science co-extensive with our own, and as he has some rights which we, even as scientists, are bound to respect, we must seek to gain from such cases all the good we can for our cause, without visiting upon him the displeasure due solely to our own want of skill.

It is with some such feelings and with a desire again to point out the necessity of "explaining symptoms," whether of disease or drug action, by showing how deceptive they may be, that I venture to present the following history of an enigmatical case.

Mr. S. T., aged 43, was sent to me on January 16, 1890, with the following history and present condition:

He had been suffering for two months from pains in and about his right eye similar to those about to be described. He had noticed for some time previous to the onset of his eye-symptoms a difficulty in concentrating his mind on any subject; he could not think readily, his memory was becoming treacherous, and his disposition irritable and worrisome, and the smallest trifles served to excite him. During the day he was comparatively free from pain, but with the going down of the sun his troubles began; the pains becoming so severe as to deprive him of sleep. Toward morning the pains abated, and again during the day were only of a dull, endurable character. His severe pains were particularly around the eye and down the right side of the nose, an intense gnawing, entirely banishing sleep and compelling the patient to rise and move about from one place to another in the vain endeavor to ease his anguish. There was also some pain in and behind the right ear, frequently of a sharp, shooting character. The right side of the nose felt numb at times when lying down, giving place to a trickling sensation when rising. Occasionally throbbing or sharp pains in the temples and in the region of the carotids.

These various pains seem at times to be concentrated near the right parietal protuberance, causing the scalp in that place to become sensitive to the touch. The patient suffers also from coldness of the

extremities. His appetite is poor and his gastric digestion easily disturbed. Tongue usually heavily coated, yellow, with offensive breath. Has a daily but insufficient and unsatisfactory evacuation of the bowels. Has lost considerable flesh, and, in general, has a sallow, cachectic look.

On examining the eye affected, found a swelling in the upper outer part of the orbit, bulging out the upper lid in that location sufficiently to suggest most readily an orbital tumor or some disease of the lachrymal gland. The swelling was soft and yielding, however, not doughy, and was sensitive to pressure, especially to deep pressure.

There was partial paralysis of the upper lid—of the external rectus and of the superior oblique muscles, with a pupil moderately dilated and very sluggish. Vision in this right eye was lost entirely, which, of course, explained the relief (?) of the diplopia that had been a very annoying symptom in the beginning of the attack.

Eyeball slightly flushed and no ciliary injection ; tension normal, media clear.

With the ophthalmoscope found the veins of the fundus much enlarged, arteries about normal in size, with the outlines of the disc somewhat indistinct. The fundus otherwise normal.

The patient solemnly denied a syphilitic history, but confessed to being a periodical hard drinker. Previous to the attack had worked very hard, day and night, both with his eyes and head, as bookkeeper for various concerns. Had been simply run down from overwork.

The symptoms, I *thought*, pointed to a growth of some kind, probably malignant, within the orbit in the neighborhood of the entrance of the optic nerve, which, by its extension, was producing the ever-widening complex of symptoms. The prognosis was, of course, grave.

With a conservatism which may seem culpable to some, and to myself even at times, seemed hazardous, I determined to risk internal treatment before removing the eye, which I feared ultimately to be obliged to do, or even making an exploratory incision, so much employed just now in abdominal surgery.

In spite of the positive denial on the part of the patient of ever having had syphilis, I began the treatment with the iodide of potash, but found, in apparent confirmation of the truth of his assertion, that this remedy not only did no good, but seemed to aggra-

vate the general condition, without causing any symptoms that could be ascribed directly to the drug. I then proceeded to use various remedies suggested by the varying conditions of the patient with the following results:

By February 1st, from January 16th, nux vomica having been the remedy last used, the swelling in the upper part of the orbit had markedly decreased in size; the ptosis was less; on looking straight out there was no strabismus, although there was still inability completely to rotate the eyeball outward; the paresis of the superior oblique had been cured entirely; and vision was beginning to return in the periphery of the field, although there was still a central scotoma.

By May 12th the ptosis had disappeared entirely, also the orbital swelling; but there remained a slight insufficiency of the external rectus on extreme abduction, as well as a slight sluggishness of the now natural-sized pupil.

During this time the pains had been subsiding gradually and the general health of the patient improving. Both patient and doctor were so much encouraged by this progress that permission was given to visit the patient's store to seek to relieve the tedium of the long illness. Unfortunately, the visit was too prolonged and was attended by some use of the eyes. The consequence was that the pains returned, this time slightly in the right eye, the one originally affected, but worse in the left, and in this one we had the various stages of the previous history repeated, but with greater rapidity. Violent pains, exactly similar to the original ones now attacked the left eye. Then followed convergent strabismus, diplopia, ptosis, almost complete, and misty vision and finally total blindness. My conservatism received a shock. Here seemed the history of a natural pause in the course of a disease, perhaps entirely independent of my treatment, followed by an equally natural extension of the presumably malignant process to the nerve of the other eye.

Cheering the patient with hopes that I hardly shared, I changed to *causticum* and then *ignatia*, and in consequence of which I think I may venture to say, at the end of another month, *i.e.*, about the middle of June, all obtrusive, objective and subjective symptoms had vanished, and we found on testing, R. E. V. $= \frac{10}{70}$, L. E. V. $= \frac{0}{10}$, and opthalmoscopically, the right eye still with some slight signs of venous stasis, and in the left the fundus normal.

AURAL PRACTICE.

BY H. K. HOY, M.D., BELLEFONTE.

THE writer selects as the title of this paper the subject Aural Practice, because of its great importance and because of the fact that if any one branch of our medical work is slighted, it is this particular branch. Could the vast multitude of deaf people in this world be marshalled before us, what an army it would make, and when we contemplate the thought that the large majority of these are so through clear ignorance and neglect, surely the title of this paper needs no apology at my hands.

The writer is fully aware that justice cannot be done to the subject in a short article like this, but if a few ideas can be thrown out that will cause thought upon this branch of the profession, and closer investigation into it, enough will have been done to warrant the effort put forth.

It is not the writer's purpose to delve deeply into the pathology, nor into the materia medica of aural diseases—Roosa, Houghton, Sterling, Cooper and others give us the best to be had at the present time, and they give us enough to enable us to do good aural work.

There has been a time, when, if an ear patient presented himself to the writer for treatment, the latter would as soon have seen that patient apply to the other doctor across the way, and especially was this the case with that large class of persons affected by deafness, but with increased knowledge and experience, those patients are today welcomed equally, if not more generously, with those who suffer other ills.

When patients suffering from acute ear diseases come to us what can we do, and what can we promise them? A sore ear, otitis media acuta for example, causes the patient to think that he is the most horribly pained being on earth; a toothache or a felon even is as nothing compared with the agony of this patient, especially if mastoid complication threatens. What shall we do to relieve him? He must have relief, and he wants it quickly.

The repertories refer us to the internal administration of such remedies as aconite, belladonna, chamomilla, hepar sulphuris, plantago, phytolacca, etc., as the indications direct in the early stages, while paracentesis of the membrana tympani may save it, and if the case goes on to mastoid disease, free opening into the mastoid cells may be necessary, and in the progression of the disease the kalies, calcaries, silicia, etc., etc., each has its place; but all this requires time, and relief comes too slowly to suit the patient, and what else can we do to relieve? We can apply chloroform, but this, while it does relieve the pain, irritates the external auditory canal, and is therefore objectionable.

A solution of 2 to 4 per cent of the muriate of cocaine warmed in a dropper held in the closed palm of the hand has acted magically in the writer's hands in easing these middle ear pains. I would here state that a cold application should never be put into a sore ear.

Then there are the medicated warm waters, aconite, belladonna, plantago, one to ten, to one to forty, applied to the external auditory canal. Each has its place, and many a time has aconite applied in this way in incipient cases apparently ended the whole trouble.

The application of warm water must not be forgotten, especially in cases somewhat advanced. Apply it with the douche and by the gallon every few hours. Lately a patient appeared for treatment who had for several nights walked the floor with pain. Hepar was administered. The patient returned still complaining. The warm douche was recommended. These applications were so soothing that for several days and nights the warm water was adhered to at intervals of a few hours, when the hearing, which was reduced to watch pressure, returned and the pain had entirely disappeared. Before consulting with the writer for treatment, irritants had been used, so that the external auditory canal was very much swollen, and no view of the membranic tympani could be obtained.

If patients with these inflammatory ailments come early enough we need rarely go further than indicated in the foregoing, ruling out the surgical references. But as many do not come until destructive changes have set in, it opens the highway to the exercise of our highest knowledge and best tact and patience to save what we may of the wreck before us, and it is really wonderful to

learn what we can sometimes save in these cases. From a destruction of two-thirds of the membrana tympani, with almost entire loss of hearing, repair has been known to take place, so that cicatricial tissue replaced the loss to the membrane and good hearing been re-established. Let me here say that *silicia* is *the* remedy in bringing about repair in suppurative destruction of the membrana tympani.

Passing now from this phase of the subject, we come to another class of cases, those that have run the rough course to destruction, either of the middle ear or of the internal ear, and in this we find an ample field open to some inquiring mind that will show us the way; but this much we can know, viz.: whether we can encourage our patient, whether we can promise him but little, or whether we must resign him to a sad fate.

In these cases patients generally come to us because of otorrhœa, or because of impaired hearing. The otorrhœas we can generally cure by means of indicated remedies internally, and by the aids of peroxide of hydrogen, healing and disinfecting powders and solutions applied to the ear. But when it comes to deal with the cases of deafness, although the known treatment is simple, great discretion should be exercised in diagnosing each case. Method is imperative in these cases, and our first aim should be to see that no obstruction exists in the external auditory canal. About the greatest happiness that you can bestow upon an elderly gentleman who has been deaf for years, is to send him away from your office with good hearing, even though you did remove only an amount of hardened cerumen. Why such a patient can not get done telling his friends what a wonderful service you have done for him. He will even tell his friends what wonderful instruments that doctor has.

In examining such a case we must not, however, make the mistake that a New York specialist (?) did; a Philadelphia specialist would not fall into such an error. The case to be related was told me a a year ago by my lately deceased friend, Dr. Gerheart, of Tyrone, this State, and he vouched for its truthfulness. The facts in the case were that a deaf friend of his, an elderly college president, decided to employ aural skill, and nothing short of the skill of New York city would answer the purpose. So to New York city he went, and in New York city he found a specialist, and this specialist examined this college president's ears, and in these ears he

found a disease to which he gave a tremendous name, and then he got his fee. The patient went home sad and dejected, resolved most likely to die from this terrible disease, and he was ready then for anything or anybody that could save him. With no thought or hope of help a home physician of no aural pretensions was consulted. He examined the ears, removed a large quantity of impacted cerumen, and to the utter astonishment of his patient he found that all that was needed was that his ears required a thorough cleaning out, the hearing having as it were returned instantly.

In the removal of cerumen that has become very hard, as in accumulations of years, much patience is sometimes required, and the syringe, with warm water highly saturated with bicarbonate of soda, are probably the safest aids to call into requisition. Often sittings upon succeeding days are necessary before we can succeed. The writer has seen after repeated trials a plug of wax come from an ear that seemed certainly to have impacted upon it a layer of the membrana tympani.

Then after a certainty that we have an open external auditory canal, having a full view of the drum, or what is to be seen at the inner end of the canal, if deafness still exists the next point is to ascertain whether the trouble exists in the middle ear or in the internal ear, as it must have its location in one or the other, or both. This may be done with considerable certainty by means of the tuning fork test or by the improvement or impairment of the hearing in a noisy place.

If the tuning fork is heard better through the air as it vibrates near the ear than it is when applied over the mastoid process, the test signifies that the acoustic nerve in the internal ear is affected. If the reverse obtains, if the vibrating tuning fork is heard more distinctly when applied to the mastoid process than when vibrating through the air or held close to the ear, the evidence of the test is that the deafness may be referred to the middle ear. Of course, deafness might result from disease in both the middle and internal ears, and this would complicate a case, and to the bad interest of the patient.

The patient also who hears best in a noise, as when riding in cars or in a crowd where many persons are talking, has in this fact evidence that he suffers from affection of the acoustic nerve, while he who hears best in a quiet place undoubtedly suffers from the effects

of middle ear disease. The question here naturally arises, why shall we differentiate thus closely as to the location of this impairment of hearing, and the answer, and a very important one to the patient, is that, while a certain line of treatment will do great good to the one class of patients it will work great injury to the other.

The patient who is deaf from middle ear changes will almost invariably be benefited by inflation, be it by the methods of Politzer, Vansalva or by the use of the aural catheter. The patient who is deaf by reason of disease of the acoustic nerve will not only not be benefited by inflation, but it will most certainly do him harm, and in such cases this method of treatment should be entirely discarded. The history of these cases is that they gradually grow worse, and inflation but hurries on the destructive changes. All that we can do for these patients is to continue them upon internal remedies, and although it is claimed by some eminent aurists that we can help every case, in the writer's mind it is a matter of doubt. Perhaps the hearing can be held intact longer, but no such case can be called to mind where hearing improved.

Inflation, though, is the great thing in treatment of middle ear deafness, and as an illustration would cite a case of deafness, resulting from otitis media catarrhalis in a young lady, of six years' duration. Upon Sept. 3, 1889, she applied for consultation and hearing was then reduced to firm pressure of the watch upon the ear before it could be heard. Mastoid conduction of vibrating tuning fork fairly good, aerial conduction of the same poor. Encouragement was given her to undergo treatment. Improvement for a time was slow, but the hearing gradually returned until May 24, 1890, R. H. $= \frac{14}{40}$ before inflation and $\frac{20}{40}$ after inflation, and L. H. $= \frac{20}{40}$ before inflation and $\frac{30}{40}$ after inflation. Since then there has been no improvement, but by occasional inflation the hearing continues good. Calcarea phosphorica has at various times been given this patient with the hope that it might do something against the changes brought about by the catarrhal process in the ears.

Other cases could be cited, of short duration, where inflation restored better hearing, and restored it by simply a few sittings, but as the foregoing is an illustration of the kind that, untreated, would go entirely to the dogs, as it were, it may suffice.

Trusting now that I have made good my promise to our late

president of this society, the lamented Dr. Trites, when he solicited me to prepare something for this bureau, and hoping for a kindly reception of this production, it is respectfully submitted.

DISCUSSION.

Dr. W. H. Bigler, in discussing Dr. Hoy's paper, said that he preferred the dry method of cleansing the ear whenever it was possible to employ it. In many cases, the hardened wax can be removed in a solid lump. The syringe leaves the parts in a soaked condition. The dry treatment of middle ear suppuration he thought preferable to the wet. Where, in a chronic case, there is perforation of the membrana tympani, he would prefer that it not heal, as the hearing is generally better while the opening persists.

THE EYE IN RELATION TO GENERAL DISEASE.

BY W. W. SPEAKMAN, M.D., PHILADELPHIA.

Introduction.

Mr. President, Gentlemen of the Homœopathic Medical Society of the State of Pennsylvania:

In presenting this paper for your consideration, it is my intention to briefly consider the relations which exist between certain general diseases and the eye.

A minute description of the symptoms or treatment of either have been avoided, except in such cases as seemed to require it.

The subject, I think, is one in which the practitioner and the ophthalmologist are mutually interested, not only for the intelligent promotion of science, but for the health and well-being of their patients.

While age, sex, habits and occupations can not be considered under general diseases, they yet play such an important part in their predisposition and influence upon all organs that I will briefly first consider them.

Age.—The arcus senilis (the crescentic opacity at the periphery

of the cornea) is usually present during advanced life, and is due to a fatty degeneration of the cornea; it occasionally is present earlier in life, and is then considered by some to be indicative of fatty heart with degeneration of the arteries.

The conjunctiva is liable to chronic catarrhal inflammation and not infrequently calcareous concretions form under it, both on its palpebral and ocular surfaces.

The sclerotic becomes firmer and denser with advanced life, and this fact is not to be forgotten in estimating the tension in old people.

The lids and loose connective tissue surrounding them may become œdematous especially if there be a tendency, from any cause, towards a general anasarca.

The lower lid may, through the relaxation of the tissues, fall away from the globe and cause an overflow of the tears by displacing the puncta.

This may be very slight or it may be so great as to result in actual ectropion. Entropion, on the other hand, is more liable to occur in the upper lid, owing to the absorption of the tarsal cartilages; this may in turn cause a superficial ulceration of the cornea from the scratching and irritation of the cilia. The crystalline lens undergoes shrinkage and absorption and becomes less convex and less elastic, which, together with loss of power in the accommodation muscle, constitutes presbyopia, or old sight.

Cataract (opacity of the crystalline lens) of various forms and in various stages of development is frequently found in the aged, and hence, while the actual causes of this trouble are not yet clearly understood, we may assume that age is one of the potent factors.

The so-called senile or hard cataract is the most common, and consists in a shrinkage and disintegration of the lens fibres.

Puberty.—Errors in refraction, which hitherto had remained latent and were unsuspected, now frequently cause annoying asthenopic symptoms, such as headache, intolerance of light, pain and blurring of the print when reading, styes and inflammations of the lid edges.

The application of the proper correcting glass, together with attention to the general health and a decrease in the amount of strain placed upon the organ, usually establish a cure.

The menopause, or any considerable change in the circulation, may cause muscular and accommodative asthenopia, with photophobia and hyperæmia of the retina.

Glaucomatous eyes are frequently made worse, and detachment of the retina is more frequent at this time of life.

Pregnancy, especially in primipara, may be accompanied by hæmorrhages into the retina, due generally to a temporary albuminuria. Should these be extensive or in the region of the macula lutea they will suddenly and seriously endanger the vision, and abortion may be the only avenue of escape.

I recently saw a case, while associated with Dr. Charles M. Thomas, in which a young woman, 28 years of age, was pregnant for the first time.

All went well until the beginning of the sixth month, when she became almost blind in one eye, and in a few days the second eye became affected. Ophthalmoscopic examination showed extensive hæmorrhages into both retinas. Premature labor was at once induced, and in a month the vision had returned from $\frac{5}{100}$ to $\frac{5}{30}$ in one eye, and from fingers at three or four feet to about $\frac{5}{100}$ in the other.

Occupations and habits of course affect the eyes directly as they relate to them and indirectly through the general health. The accommodative muscle in seamstresses, bookkeepers and others engaged at close work gives out comparatively early in life, owing to the increased strain placed upon it. Miners are sometimes subject to nystagmus, a rapid and nervous oscillation of the eyeball, supposed to be due to looking upward in the dimly-lighted mines, while those engaged in working in bright lights or in high temperatures are subject to defective acuity of vision and hyperæmia and congestion of the retina.

The poorly nourished and poorly clad children of the lower classes in our larger cities are frequently subject to phlyctenular keratitis and conjunctivitis. Alcohol exerts a somewhat uncertain action upon the eye; during acute alcoholism the retina is engorged and the optic disc reddened.

Many claim that alcohol is the cause of a large percentage of the amblyopias, while other equally good observers argue that as nearly all drinking men use tobacco we are unable to estimate its

true effect. Undoubtedly inanition also has a great influence, for nearly all drunkards are poorly fed, and in the siege of Paris where food was scarce and where stimulants were freely supplied there were many cases of amblyopia and amaurosis reported.

Tobacco also has an undoubted effect upon the vision, when it has been used to any great excess and for a long period, although the amount and length of time varies much with the individual, many never being at all affected.

Lead-poisoning may cause atrophy of the optic nerve subsequent to a neuritis or independently of it. The retinal arteries in either case are usually contracted and smaller.

A transient amblyopia may be the result of lead-poisoning and is usually symmetrical. As a rule other characteristic symptoms are present.

The vapor of the bisulphide of carbon may, if inhaled for a long time and in a concentrated form, cause a chronic optic neuritis with consequent failure of sight, especially for central vision.

Quinine taken for long periods has caused an apparent diminution in the vision. The disc is pale and the retinal arteries are diminished in size. The prognosis is, however, good, sight usually returning, although occasionally not for months, and the field always remains permanently contracted.

Santonine poisoning causes a yellow tinge in the conjunctiva and occurs in the vitreous, while yellow vision is a very prominent symptom.

Opium causes a contraction of the pupil, often to a pin's point.

Various drugs and their active principles act as mydriatics and myatics, but a discussion of them does not rightfully belong here.

The various diatheses, especially the strumous and rheumatic, have an influence upon the organs of vision.

The strumous subjects, especially the children, are liable to keratitis and conjunctivitis of the phlyctenular form, the lids are frequently the seat of chronic ciliary blepharitis, and many cases lose their cilia.

The rheumatic individual seems predisposed frequently to inflammations of the iris and choroid. The iritis is usually of the plastic form and often occurs in both eyes; cyclitis and choroiditis are per-

haps less common, but still frequently enough to permit of us assigning them to this cause.

Inflammations of the episcleral tissue are also frequently dependent on a rheumatic dyscrasia, and are especially obstinate to treatment. Rheumatism of the ocular muscles gives rise to asthenopia and pain on moving the eyeballs.

Syphilis, both in the acquired and inherited form, has a pronounced influence upon the eye.

The conjunctiva or lids have occasionally been the seat of the initial lesion.

The iritis usually occurs during the secondary stage or at the transition to the third.

It is not apt to be distinctive, although the amount of plastic exudation and the pain are usually greater. There also seems to be a greater tendency for the exudation to organize, and consequently the danger of adhesions to the anterior surface of the lens is greater.

In some cases gummata form on the iris and cause a bulging and vascularity at the point they occupy ; they vary in size from a pin's head to a grain of shot, and are of a pinkish, yellow color.

The choroid may also become inflamed, and either or both the central or the disseminated forms be present.

The retina or optic nerve may also participate, either separately or in conjunction with the choroid. As a rule, we have opacities in the vitreous, which may be fine and dust-like, or which may be larger and more or less completely obscure the fundus.

In the inherited form, iritis is rather less common, but occurs in the secondary stage. Keratitis, on the other hand, is much more frequent than in the acquired form, and is usually of the interstitial type. The cornea has the appearance of glass ground on one side, and viewed from the unground surface, the polish of the cornea being frequently undisturbed. This will frequently be found associated with the notched incisor teeth, known as Hutchinson's teeth. As the cornea and ciliary body are frequently obscured during this trouble, and as they are both especially liable to inflammation, it is well to instil atropine to anticipate any such trouble. Where gummata form in the brain and produce pressure, especially if they be in the region of the optic thalimi or optic tracts, they may cause a

neuritis or a neuro-retinitis with subsequent atrophy, or a paralysis of one or more of the ocular muscles may ensue.

Meningitis is a frequent cause of inflammation of the optic nerve, but it appears to depend largely on its location. Out of sixteen cases of injury of the head ending in death, Edmunds and Lawford never found basic meningitis without neuritis, whereas, they found no neuritis where the inflammation was limited to the convexity.

The tubercular form of meningitis is nearly always attended with papillitis with subsequent atrophic changes and loss of vision.

Hydrocephalus rarely causes a neuritis, but may at a later stage produce an atrophy of the optic nerve.

Locomotor ataxy and general paralysis of the insane are occasionally preceded by paralysis of either one or more of the orbital muscles, causing diplopia, or by the presence of the Robinson-Argyle pupil.

Megrim is frequently preceded or accompanied by a temporary loss of sight, more or less complete. The exact cause of this is, I believe, unknown, although one or two theories have been advanced. One is that the neuralgic disturbance passes rapidly down the optic nerves, causing a sudden cessation in function, while the other is that the retina is suddenly deprived of its blood supply, producing a transient anæmia.

Gonorrhœa has its principal effect by direct contact of the virus to the conjunctiva, causing a severe form of purulent conjunctivitis, which not unfrequently runs on to entire destruction of the globe. The greatest precaution should be observed to prevent inoculation of the sound eye.

Leprosy causes inflammations of cornea, iris and choroid similar to those of syphilis. The keratitis is of two forms, the interstitial (similar to the ordinary) and the nodular.

Chest diseases, except so far as they may cause a congestion of the retina through a venous stasis, produced by obstruction of the blood passing through the lungs, have but little effect. This has been noticed in pneumonia and pleurisy, but it is rarely, if ever, sufficient to cause retinal hæmorrhage.

In phthisis we are apt to have a dilatation of the retinal vessels, causing a marked contrast to the anæmia of the skin.

Affections of the teeth undoubtedly occasionally cause interfer-

ence with the vision through irritation of the dental branch of the fifth. Hutchinson and Pallizouski both report interesting cases where the removal of a decayed tooth, with the evacuation of a small quantity of pus, was followed by restoration to sight in cases of complete amaurosis.

The accommodation is also undoubtedly interfered with and its range considerably diminished.

Gastric and intestinal troubles have an undoubted effect upon the vision, bilious attacks being frequently accompanied by transient dimness of sight, while temporary strabismus in children not unfrequently depends upon the presence of worms or other irritation in the intestinal tract.

Erysipelas may affect the eye by extension from other points. Great chemosis is always present. Orbital cellulitis is sometimes developed, and death may result from extension of the disease along the optic nerves to the brain.

Atrophy of the optic nerve and keratitis may also result as sequelæ of erysipelas.

Diseases of the liver, especially where jaundice is a prominent symptom, are apt to cause interference with the vision and asthenopic symptoms.

The conjunctiva is usually of a yellowish tinge, and in severe jaundice yellow vision is not uncommon, while Yaeger and Bullwell report several cases of hæmorrhage of the retina occurring during the existence of hepatic disease. Diseases of the kidneys are frequently attended by changes of the retina, of which hæmorrhage and fatty degeneration are the most prominent symptoms.

The class of cases met with in the general hospital are frequently the ones where the least destruction of vision has occurred, while those in the ophthalmic hospitals show marked retinal changes with few general symptoms.

Retinal changes are most frequently met with in the contracted kidney of Bright's disease, although various other kidney affections, such as glycosuria and the albuminuria of pregnancy, may show forms of retinal trouble. The retina may present various changes, not only in different cases, but in various stages of the same case. The disc and surrounding edges are usually at first slightly blurred, associated with a few irregular yellowish-white patches scattered

throughout the retina, especially in the region of the macula lutea, where they may be of small size, no larger than a pin's head.

Hæmorrhages are usually found, and vary in size and color, depending on the length of time they have existed.

Diabetic mellitus is much less common than the albuminuric form, and it is often impossible to distinguish between them. Leucocythæmia may or may not be attended by changes in the retina. There are usually white patches due to collections of leucocytes that have escaped by diapedesis from the vessel walls. The fundus is a pale orange-yellow and the retinal vessels are light in color.

Progressive pernicious anæmia is marked by a decided tendency towards hæmorrhage, especially surrounding the optic disc, which may be associated with white splashes in the retina. The fundus participates in the general pallor.

Diphtheria may or may not be attended by a similar inflammation of the conjunctiva, and a diphtheritic conjunctivitis often exists without the presence of a general trouble. The membrane usually forms in the fold of the lids, especially the upper, and detaches itself towards the close of the disease.

Small-pox may affect the conjunctiva and cornea causing inflammation occasionally. The pock forms on the cornea, forming first a vesicle and later an ulcer with a resulting macula. Glaucomatous eyes are made worse and iritis is quite common, especially at the close of the disease.

Scarlet fever, measles, chicken-pox, and the various other eruptive febrile diseases of children are frequently attended by conjunctivitis and keratitis.

Photophobia is always present at the beginning of the trouble; the eyes should be well shaded from the light and a mild collyrium used.

EXPERIENCES IN GLAUCOMA.

BY JOHN C. MORGAN, M.D., PHILADELPHIA.

CASE 1.—A sensitive woman, brunette, about 30 years old, dressmaker, had suffered for a year or two with distress in head and left

eye. The power of vision was greatly impaired; tension excessive; almost constant pains. She received gelsemium and other drugs with improvement as to pain. Falling into the hands of a general surgical practitioner, the eye was enucleated.

Case 2.—A woman of 35 years, quadroon, seamstress, had pains in right eyeball, orbit, etc., for a year, with increased tension and impaired vision. An ophthalmoscopic examination by Dr. C. M. Thomas proved pulsation of the vessels of the fundus oculi. My diagnosis of glaucoma was duly concurred in. Prescribed a few doses of pulsatilla 200, followed by saccarum lactis. Being hypermetropic, and evidently suffering from constant eye-strain, she was at the same time fitted with glasses furnishing the best and easiest vision when at near work. All trouble ceased and the cure of glaucoma, without eserine or operation, may be fairly claimed.

A recent case, with all details here following, is the source of much present satisfaction.

Case 3.—Mrs. O——, æt. 45 years; nervous, sanguine temperament; has for many years abused her eyes by wearing her parents' glasses and by sewing, reading, etc., at night, and in other ways. She has almost constant headache, especially on left side. Is subject to two forms of it; one, with sick stomach and constipation; when at its worst, with clammy sweat and prostration. The other form is of the "nervous" type, with neuralgia in head and eyes.

For an attack of the gastric form, she received early, veratrum album 200, four doses in one day and sac. lac., with the effect of aborting it, relieving constipation, etc. She still persisted in the abuses mentioned, and took successively, pulsatilla 200, nux vomica 200, and sulphur 200. (The left eyelids were kept half closed.) The pains getting quiet at last, her refraction was tested, and reading glasses prescribed, with perfect correction, viz.:

$$\text{R. E.} + 3.25^{s} \bigcirc + 0.50^{c}, \text{ ax. } 60^{\circ};$$
$$\text{L. E.} + 3^{s} \bigcirc 0.50^{c}, \text{ ax. } 120^{\circ}.$$

The examination itself, despite all care, had the effect of causing some pain. This, however, directly subsided. She continually resorted to cold water applications for palliation; but as continually did washing, ironing, dressmaking, reading at night, drinking largely of lemonade at night.

And now set in extreme symptoms of pain in left side of head, temple and occiput; shootings in left eye, up to brow, forehead and temple; excessive tenderness of eyeball, at the insertion of the superior oblique muscle; and withal, a frightful degree of tension of the ball, as shown by touch; and the iris, held at the fixed points of pupil and ciliary border, presented a convex shape, and slightly darkened tint. The ball felt "so stiff that it could not be moved at all;" vision was in abeyance, and the other eye was affected with similar disability of less grade. Stooping forward greatly increased the pains, and these moved from before backward. I could not venture to examine with the ophthalmoscope.

All of this symptomatology is characteristic of acute glaucoma, and iridectomy or sclerotomy, eserine, etc., were authoritatively brought into prominence. Still, the "similar" drug might have a short trial, provided it were not given to excess and to the point of aggravation. The symptoms of spigelia were plain: Shooting pains, left side, going backward; worse from stooping forward. The 200th was given; four doses, with intervals of four hours, beginning at bedtime, with plenty of sac. lac. in solution.

She passed a good night, and the next day there was great amelioration. On my urgent representation of the danger of loss of the eye, which she had herself begun to realize, she consented to lie in a dark room, wearing a broad eyeshade over both eyes. All symptoms improved. Tension abated—the eye began to look natural again. Cold applications still gave comfort, and were permitted. This modality is not *prominent* in spigelia, but *exceptional.*

As relief came, she soon put aside all caution, and after a week, the pains returned. She again took four doses of spigelia, six hours apart and resumed a more cautious regimen, after the statement of an impressively bad prognosis, and this frequently repeated. Relief was soon again had, and her destructive methods were then duly resumed; stooping, cooking, etc. The "cold wave" of our early July came upon her whilst asleep by an open window and severe pain ensued, and which was aggravated by the habitual cold water. Moreover, the side of the head was so sore as to prevent her lying on it. The temporal and occipital nerve-beds were especially sore on pressure—and the pains apparently originated in them. By careful pressure with the back of my thumb-nail, I was able to

determine that this soreness was *periosteal.* Prescribed mercurius vivus 200th, four doses, with intervals of six hours, and sac. lac. The result was excellent; the symptoms subsided, including the soreness, and she could lie with comfort on the left side.

All went well for some days, but knowing her recklessness, I gave her, on July 12th, four more powders—to take one or more as needed, should the pain return. This happened on Sunday, the 13th, and she took several powders with prompt and complete relief, once more. However, on stooping and then rising, the left side of the head would throb painfully. I kept her supplied with the powders of mercurius vivus 200 and she took them repeatedly, with good effect. On Saturday, July 19th, she took an excursion; a long ride by steamboat, the sun's glare and a cool wind being constant. She was thinly clad, but her eyes were protected by dark plane glasses and a shade.

At night, she took a powder, but at 2 A. M., had severe neuralgic pain from the eye to head and upper jaw, for which she took another and in the morning was pretty well again. The pain was less in the eye, mostly in the head; but the soreness of bone was less conspicuous; however, cold water did not agree and was put aside, after trial.

July 25th. Was working most of yesterday at dressmaking; washing and ironing the other days; thinks the medicine ought to enable her to do as she pleases with impunity. To-day, feels better, but had pain last night. It is worse still, when leaning downward and forward. Gave as a tissue-remedy, one dose of calcarea carbonica 200, dry.

Improvement was now more steady. However, a few days later, I discovered that she has been in the habit of taking blackberry wine occasionally, from a bottle (well-washed), formerly containing "beef, wine and iron." My prescriptions have, therefore, had to contend with this unknown drug element. Besides, her washing, ironing, dressmaking, and night-reading were still persisted in. The habitual and long-standing "bilious" tendency, with its headache, also inclined to recur, frequently in the early mornings, lasting until afternoon; affecting the eye as usual, without glaucomatous symptoms, but with tenderness of the deep parts in front of the orbicularis tendon.

One peculiarity has been constant, viz.: that if she waked, say at 4 A. M., and still more, if she rose from bed, and then lay down again to sleep, *the aggravation following was severe.* She now parted with an only daughter and the headache was quite troublesome. Prescribed Ignatia 200, four doses in twenty-four hours, followed by sac. lac. She then left the city on a vacation and improved steadily, until two days prior to her return, when she slipped on the stairs, causing a downward concussion, and the headache returned and was but partially better after arriving at home on August 20th; the eyeball and orbit being affected. Repeated calcarea carbonica 200; two doses—at 10 A.M., and at bedtime. The pains subsided rapidly once more. Now is free from all distress.

August 29th. Yesterday, ironing and perspiring in a cool draught, caught cold and has frequent running of clear water from the nose; left-sided headache. Gave natrum mur. 200th, every six hours, four doses.

August 30th. The cold is better; *the eye is well.*

TUBERCULOUS LARYNGITIS.

BY ISAAC G. SHALLCROSS, M.D., PHILADELPHIA.

As to the nature of this disease there appears to be a great variety of opinions. Beverly Robinson insists upon the "non-tuberculous and essentially catarrhal condition of the large majority, if not all, of the laryngeal conditions which are encountered in pulmonary phthisis." Sir Morrell Mackenzie also tells us that "tubercle appears to play a very secondary part, if any at all," in the production of laryngeal phthisis. On the other hand, Lennox Brown adopts the view of Virchow, who recommends the larynx as the most appropriate place for the study of true tubercle. From a careful study of this disease, both at home and abroad, we are led to believe that it is of a tubercular nature. We are also led to believe that tubercle may primarily affect the larynx, although it is generally secondary to lung involvement. Numerous cases have been reported in which the tubercular infiltrations and ulcerations were present in the larynx

a long time, in some cases years, before the disease attacked the lungs; and of late, post-mortem examinations have revealed the fact that tuberculosis, although it generally does, need not necessarily, and does not always exist, primarily in the lungs.

Predisposing to this disease we find the same causes as for all other forms of tuberculosis; *i.e.*, a low state of vitality and poor recuperative powers. This low state of the health may be either hereditary or acquired. Any cause of general debility resulting in nervous or functional aphonia is also a predisposing cause of laryngeal phthisis. The use of the voice, as in clergymen, auctioneers, army and navy officers, etc., may produce a catarrhal condition of the laryngeal mucous membrane, and this, no matter how produced, is a good soil for the tubercle bacilli. Thus we find in patients suffering from tuberculosis that those who have previously suffered from catarrh are more liable to have the laryngeal form of the disease than those who have a normal mucous membrane. Then again, on account of their greater exposure to the inclemencies of the weather and their love of tobacco, men are more frequently sufferers from catarrh than women; and the statistics of laryngeal tuberculosis show that almost three out of four cases of this disease occur in men.

In by far the greater number of cases of laryngeal phthisis the disease is primarily in the lungs. About thirty per cent. of all cases of pulmonary phthisis have the disease secondarily in the larynx.

In the acute form the first thing that we see is a marked congestion of the mucous membrane; but most of the cases that present themselves are of the chronic variety, and in these there is always anæmia, a peculiar paleness of an ashy yellow color, with engorged bloodvessels ramifying over its surface. This appearance not only presents itself in the larynx, but includes the mucous membrane of the entire laryngeal wall and soft palate, and when seen should alone be sufficient reason for a thorough examination of both lungs and larynx.

The primary seat of infiltration, according to frequency of occurrence, is first the inter-arytenoid space, then the coverings of one or both of the arytenoid cartilages and the aryepiglottic folds, next the epiglottis, and then the vocal cords. The appearance when both the arytenoid cartilages are infiltrated is that of two pear-shaped bodies,

with their bases together and their apices extending upward and forward. When the epiglottis is the seat of infiltration and tumefaction, the swelling is often so great as to cause an examination of the glottis to be extremely difficult, if not impossible. In the latter stages, its appearance is described as "turban-shaped," the original outline having disappeared. Another peculiarity of tubercular infiltration of the epiglottis is the fact that almost always the glottic and not the lingual surface is the one attacked, this being one of the signs of differentiation between this disease in the next or third stage and ulcerations due to syphilis, where the reverse holds good.

When the tumefaction and infiltration are in the inter-arytenoid space the swelling is often so great as not to allow of the approach of the arytenoids in phonation, thus explaining in many cases the so-called paralysis of the larynx in this disease. In other cases this condition is explained by the infiltration which sometimes takes place in the muscles of the larynx, and in still other cases the cause lies in direct pressure on the recurrent laryngeal nerve, due to solidification of the apex of the right lung or an enlarged cervical gland on either side. The vocal cords lose their pearly appearance, and are seen to be congested and thickened; or they may be entirely hidden by the swollen ventricular bands.

A microscopic examination in this stage of the disease reveals the deposit of tubercle in the mucosa and sub-mucosa, while the epithelial layer of the lining mucous membrane appears healthy, thus annulling one of the older theories, which claimed that the ulceration which we find in the next stage of the disease to be due to the corroding effect of the sputa from the lungs.

This grayish, semi-solid infiltration is followed by a characteristic ulceration. At first the appearance is that of small yellow spots, perhaps clustered in groups, in the mucous membrane. As the degeneration goes on, these break down into ulcers. These ulcerations are small, and there is a marked tendency to coalesce, giving them the appearance of having been nibbled by mice. The floor of the ulcer is pale, granular and slightly depressed, the ulceration tending to spread laterally rather than deeply. The margins are slightly excavated and fairly well marked, and the surrounding tissue has the characteristic pale appearance.

Any or all parts of the larynx may become ulcerated. When

the epiglottis is the part affected, it is the posterior surface or free edge that is ulcerated generally; but the entire organ may be eaten away, leaving nothing but a stump remaining. When the necrotic process attacks the vocal cords, it generally presents the appearance of having been eaten along its entire length by a worm. Occasionally only one portion, and that the posterior, is the subject of necrosis, and then the band may become separated from its vocal process. Usually both cords are affected. Extensive perichondritis often complicates the case at this period. When the inter-arytenoid space and the coverings of the arytenoids are the subject of the disease, the entire arytenoid and, sometimes, parts of the thyroid cartilages, have been lost as the result of this complication. In some cases the entire cricoid cartilage has been expectorated after a perichondritis in that region. New growths, such as papillomata and granulomata, are occasionally found in phthisis laryngis.

The constitutional symptoms of laryngeal tuberculosis are the same as those of the pulmonary form. The cachectic appearance is well marked. Emaciation is more marked than in the lung disease, due, undoubtedly, to the inability of the patient to take nourishment. Increased frequency of pulse, and the evening rise in temperature, are found to be the same in both forms of the disease.

The patient first complains of some hoarseness after talking. The voice may start all right, but in a short time it becomes husky, and may run rapidly into a squeaky tone or into a whisper, due to the lodgement and dislodgement of secretion. The hoarseness and aphonia are quite marked, and are often the only symptoms of which the patient complains when first seen.

Respiration is not embarrassed in the early stages unless acute œdema sets in, which is not frequently the case, the œdema of laryngeal tuberculosis being mostly of the chronic form. Occasionally there is dyspnœa, with stridor and paroxysmal aggravations. Sometimes, but rarely, this is so severe as to call for tracheotomy. It is surprising to what extent the glottis may be narrowed without serious symptoms.

Dysphagia is also an early and distressing symptom of this disease. When the parts can be kept quiet there is very little pain, but, as this is not possible in swallowing, there is generally acute and very severe pain at that time. Dysphagia in the early stage,

that of tumefaction, is often limited to swallowing liquids, which, on account of the inability of the glottis to close properly, allows of the admission of liquids into the larynx, thus producing severe cough. But when, in the second stage, ulceration has set in, and the disease has advanced perhaps as far as the cricoid cartilage, deglutition of solids also becomes very painful.

Cough is very exceptionally absent. At first there is simply a desire to clear the throat, due to the feeling of a foreign body in the larynx; but this soon gives way to a very severe and exceedingly painful cough. The pain is due to the mechanical irritation of the cough, and lasts a long time after the paroxysm has subsided.

Expectoration, until suppuration is established, is glairy in character. The secretion from the larynx is very moderate, and, consequently, when there is much expectoration, it, in all probability, comes from the lungs. The sputa should always be examined, according to Koch's method, for tubercle bacilli, which, if found, confirms the diagnosis.

The prognosis is always unfavorable. Very few cases ever recover, although cases of recovery are occasionally reported. Cases in which the epiglottis or pharyngeal aspect of the larynx is affected are more rapidly fatal than those in which the intra-laryngeal tissues are attacked. Death results from hæmorrhage occasionally, but more frequently from profound æsthenia or even suffocation.

Aside from the general care of the patient, *i.e*, the administration of tonics and stimulants, good nourishing diet and the proper hygienic surroundings as far as possible, in the first stage of the disease, that of anæmia, I believe, we should rely upon the indicated remedy mainly ; as adjuncts mild steam inhalations are sometimes used with advantage, but great care should be taken that the patient does not catch fresh cold after their use. Sprays are very exhausting, and should be used only in exceptional cases.

In the second stage also, I believe, more good can be accomplished by the appropriate Homœopathic remedy than by any other means, although insufflations of alum, tannin, boracic acid or iodoform are used with good results. Scarification is never to be recommended.

For the stage of ulceration Schnitzler claims cures from the persistent use of iodoform insufflations daily. Seiler uses a spray of iodoform and ether; but Schroetter and Chiari adopt the method

of Krause, *i.e*, the application of lactic acid to the ulcerated spots by means of the camel's-hair brush. Krause claims that ulcers of the posterior laryngeal wall are curable by lactic acid, and says: "No tuberculous ulcer can resist cicatrization by application of lactic acid made by a practiced hand." Almost invariably the application produces a spasm of the larynx, but this is no contraindication. Both Schroetter and Chiari claim cures by this treatment. Chiari says that he has obtained his best results from the application of lactic acid. In twenty-two cases that he has thus treated he twice saw cicatrization of the entire ulcerations, and in the rest he says the parts were kept clean, and he noticed a tendency to heal. The use of the galvano-cautery I believe to be more effective than that of the curette, because, besides removing the necrotized tissue, it is perfectly antiseptic and the heat generated is snfficient to kill all bacteria in the neighborhood. But if either method is used it should be followed by the application of lactic acid, at first in a 25 per cent. solution, afterwards stronger, as high as an 80 per cent. solution being used by Schroetter. Browne says that in purely laryngeal cases he has not found lactic acid beneficial, but believes that the application of a 20 per cent. solution of menthol in olive oil as recommended by Rosenberg to prove of greater value. I have not seen this drug used, and consequently can simply report that, from all that I can learn from those who have used both these treatments, the lactic acid appears to give the best results.

For the dysphagia insufflations of alum and morphia or the painting with a 10 per cent. solution of cocaine are used a short time before the patient takes his meals. Should this not be sufficient we must feed by means of the stomach tube. A very convenient way of administering nourishment when the morphia and cocaine are contraindicated is to have the patient swallow a whole raw egg with one gulp, he thus obtaining a large quantity of nutriment with the smallest possible irritation to the affected parts. The whole egg is also swallowed easier than a smaller quantity would be in most cases. Where there is threatened dyspnœa the larynx may be dilated with Schroetter's rubber catheters. Where this cannot be done tracheotomy is called for. This latter has been looked upon by some as a curative measure, but I have never seen anything more than a temporary amelioration of the case.

Following are some of the medicines employed, and the symptoms indicating their administration:

Argentum metallicum.—When there is hectic fever; patient sweats easily on chest and abdomen; there is rawness and soreness in the upper part of the larnyx when coughing, but not when swallowing; cough with easy expectoration of white, thick, starch-like mucus; cough is excited by laughing, which produces mucus in the larynx.

Argentum nitricum.—Raising the voice causes cough; there is inflammation and swelling of the posterior wall and lining of the larynx, attended by a sensation of a clog in vocal box; hoarseness and loss of voice; continual and vain efforts to swallow, with pain and soreness in deglutition; considerable muco-purulent expectoration; may be mixed with light blood; great tickling in larnyx, with spasmodic cough.

Arsenicum.—Mouth dry; tongue red; mucous membrane of larynx anæmic, stained with dirty spots and marked by velvety projections predicting ulceration; cough may be either absent or out of proportion to the emaciation; is generally dry, hoarse and paroxysmal, and worse in daytime; burning pain in larynx, worse on swallowing; after extensive ulceration has taken place, an acrid sero-purulent discharge comes from the ulcers, which are flat and of a bluish-red color; there is great emaciation and marked weakness.

Arsenicum Jodatum.—Hectic fever, with dry cough and titillation in larynx, worse at night; bronchial asthmatic dyspnœa; breathing too rapid, even when at rest, increasing in rapidity on exertion; general feeble respiration; frequent, short, suppressed cough, often loose with muco-purulent expectoration. Cough worse on lying down at night and between 3 and 5 in the morning. Great prostration. Diarrhœa, hurrying them out as soon as they commence to move in the morning. Aphthæ during last stage.

Belladonna.—Spasmodic cough, short dry cough from tickling in larynx; voice feeble, low and husky, dry cough from dryness of the larynx; vocal cords may be bright red.

Bromium.—Voice is hoarse, cannot speak clearly; raw scraped feeling in the larynx, provoking cough in evening; larynx painful to touch; cold sensation in larynx, with cold feeling when inspiring.

Calcarea carbonica.—Marked scrofulous diathesis; painless hoarseness in morning; dry cough, worse at night, raising with diffi-

culty white, frothy, gluey or dirty looking, putrid sputa. Necrosis of cartilage of larynx.

Carbo vegetabilis.—In persons whose vital powers are low, especially old people; venous capillary dilatation of pharyngo-laryngeal parts; ulcerative pain in larynx; with scraping, burning and titillation; putrid sputa.

Causticum.—Laryngeal catarrh of singers; the laryngeal muscles refuse to act; patient cannot speak a loud word; great hoarseness, with scraping in throat, worse in morning and evening.

Hepar sulphuris.—Sensation of a clot of mucus, or of internal swelling when swallowing. Great hoarseness, continuing for a long time, with rough barking cough, scanty tenacious muco-purulent secretion expectorated with difficulty.

Iodium.—Laryngeal and tracheal ulceration; soreness of larynx referred to one spot; voice husky; dry, irritating cough; constant hemming and hawking; tightness and constriction about the larynx, with soreness and hoarseness, worse in the morning.

Iodoform.—In the third decimal dilution has controlled the fever after other remedies had failed.

Kali bichromicum.—Chronic laryngitis with congestion; swelling of tissues and increased secretion of glutinous fluid; worse in morning, when the tough mucus nearly strangles him; voice rough and hoarse, expectoration stringy.

Kali jodatum.—Follicular inflammation, dry cough; burning tickling in throat; green sputa, when case is complicated with secondary syphilis.

Lobelia Inflata.—Aphonia. Feeling of oppression in throat. Sensation of a foreign body in the throat, impeding breathing and swallowing. Dyspnœa and asthma, with sensation of a lump in pit of the throat immediately above the sternum. Cough, short and dry. Extremely difficult breathing, caused by constriction of the chest. Empirically used in chronic stage.

Lachesis.—Hoarseness, rawness and dryness of larynx; sensitive to touch, feeling of lump in throat with sensation of suffocation.

Nitric acid.—Hoarseness; chronic laryngeal cough without expectoration, with a stinging smarting sensation as if a small ulcer were there; long standing, short, dry; cough, continuing all day,

worse when first lying down at night, but does not waken the patient from sleep; either redness or anæmia may be present.

Phosphoricum.—Irritable weakness of voice; violent tickling in larynx when speaking; dry spasmodic cough with constriction of throat; night cough from titillation or stitches in larynx; chilliness with cough. Rawness in larynx and trachea with frequent hacking cough and hawking. Expectoration of frothy mucus; may be stained with blood.

Selenium.—Tubercular laryngitis (earlier stages); cough worse in morning, straining the chest, with expectoration of small lumps of blood and mucus, tendency to hoarseness. Cervical glands swollen, hard, but not sore.

Spongia.—Dry irritating cough from a burning tickling in larynx, submaxillary glands swollen, swollen larynx, almost protruding above the chin; difficult respiration as if a plug were in the throat. Pain in larynx on touching it or on turning the neck; hoarseness, great dryness of larynx, dry barking cough and obstructed respiration, worse at night. Early stages of laryngeal phthisis.

Sulphur.—Arterial and venous vascular irritability, great impressionability of skin, and for divers discrasias as an interpolating remedy; voice deep or aphonic, worse in morning; dry cough with hoarseness; cough caused by rawness in the larynx.

DISCUSSION.

Dr. C. P. Seip, discussing the last-named communication, said that he once thought that he had cured a case of tubercular laryngitis, but soon discovered his mistake. He applied lactic acid locally, as was recommended by Dr. Shallcross. Whenever a tubercle was touched with the acid it healed; but another one appeared. Finally, he put the man on iodide of potassium, and within twenty-four hours there was a most remarkable improvement, which continued until the man was perfectly well. He thought it was a case of syphilis of the larynx.

Dr. Clarence Bartlett said, in response to a question by Dr. Dunning, that improvement under the iodide of potassium was not necessarily evidence of a syphilitic origin, though it indicated a specific cause very strongly. He quoted two cases from his own practice in which the iodide in large doses caused a most remarkable

improvement in the symptoms where the pathological condition present consisted of sarcoma of the dura mater. Still, in the vast majority of instances in which the drug causes an improvement, a syphilitic cause is traceable.

Dr. Charles G. Raue, on being called upon by the President, was greeted with loud applause. He said that he would not like to say what the trouble was in Dr. Seip's case. He did not think that it mattered very much, for the patient was cured and that was the practical point. Kali hydriodicum has in its pathogenesis many of the symptoms described in Dr. Shallcross's paper. We should take the whole patient as he is when treating him, and not mind whether he is suffering from tubercular laryngitis, syphilitic laryngitis or some other trouble. In that way we would get the best results.

Dr. H. F. Ivins thought that peroxide of hydrogen was a most useful agent for application in the treatment of tubercular laryngitis, especially in the stage of ulceration. So far as the relief of pain is concerned, the best thing is a spray of a ten per cent. solution of calendula.

AN ONOSMODIUM CASE.

BY H. F. IVINS, M.D., PHILADELPHIA.

Mr. ——, aged 46, consulted me, at the suggestion of Dr. C. M. Brooks, December 30, 1885. His chief complaint was headache. The following history is taken principally from the record made at the time.

He has had headaches day and night for the past ten years, frontal, but centres chiefly over the left eye and in the left temple; worse in the dark and lying; use of eyes, lights and noises do not annoy. The pain is usually a constant, dead, dull ache, but about four or five times a month it becomes almost unbearable. Sleep very miserable, formerly but about one and one-half hours nightly, now a little better; can sleep a little during the day, when he can fall asleep more easily than at night, because it is light; the pain is less and day-noises interrupt the flow of thought. Since the pain began, ten

years ago, there has been but one instance when the dull aching ceased. It left suddenly one evening during the winter of 1882, and did not return until the next morning, since which it has never ceased. There was much mental strain preceding the onset of the headache.

Mr. —— is tall, finely developed, mentally as well as physically, weighs about 200 pounds, and apparently the picture of health. His suffering dated from many sleepless nights and active days, during which time he was inventing and completing a complicated and extensive piece of machinery.

The symptoms pointed to a very considerable nervous deviation, and to the eyes as a probable cause of the continued aggravation, augmented, perhaps, by a long-lasting naso-pharyngeal catarrh. He was wearing R. $+\frac{1}{28}$ s. and L. $+\frac{1}{42}$ s., for reading and writing only. The ophthalmoscope revealed no irritation of the retinæ or other pathological change, but made evident the presence of a moderate hypermetropic astigmatism, which was confirmed by the shadow and subsequent tests. Vision equalled $\frac{20}{30}$ each eye, and was slightly improved by convex $\frac{1}{60}$ s., but still more by weak cylinders. Homatropine revealed the following refractive error: R. $+\frac{1}{48}$ c. ax. 80° $\frown$ $+\frac{1}{48}$ s.; L. $+\frac{1}{60}$ c. ax. 105° $\frown$ $+\frac{1}{60}$ s. The combination prescribed was R. $+\frac{1}{48}$ c. ax. 80° $\frown$ $+\frac{1}{72}$ s.; L. $+\frac{1}{60}$ c. ax. 105° $\frown$ $+\frac{1}{72}$ s., for constant use; this gave good vision for reading, and $\frac{20}{25}$ths for distance. Although the compound cylinders gave some relief and made all close work easier the headaches were not sufficiently modified to justify the statement, "a grand success," yet the glasses proved so satisfactory that they could not be discarded.

It was early thought best to turn our attention to the catarrhal condition. Mild local treatment was instituted and constitutional remedies given; the latter consisted chiefly of hamamelis, mercurius vivus and jodatum rubrum, sanguinaria canadensis and nitrate, bryonia, nux vomica, rhus, pulsatilla, phosphorus, gelsemium, ignatia, sulphur, iris, stramonium and hydrastis canadensis. The catarrhal treatment gave decided relief to the naso-pharynx and slightly modified the head symptoms, but was not sufficient to cause great improvement.

In July of last year I determined to try the efficacy of the tincture of onosmodium virginianicum on No. 35 pellets. As this remedy had

so often aided the use of lenses when not entirely satisfactory I resolved to try it here, but as the symptoms were somewhat at variance with the recorded symptoms of onosmodium, more doubt than faith accompanied the prescription. The directions given were: "Four pills every night and morning for three days should no relief be noted before the end of that time, otherwise to be discontinued until the symptoms again grow worse or until improvement stops, when one dose is to be taken." I considered these precautions necessary as I had so often seen this remedy produce drug aggravations in this class of cases. Mr. ——'s subsequent statement was: "In the evening, during a severe attack, I took four pellets; within half an hour the pain left entirely. I repeated the dose the next morning and evening, but as the pain did not return I discontinued the medicine." His statement on the 6th of this month (September, 1890) was: "Since that time I have had no chronic pain, but have probably taken the medicine eight or ten times for acute attacks, and each time the onosmodium gave prompt relief, the pain invariably disappearing within twelve hours; I generally sleep about six hours nightly."

It may be argued that this one case does little in the way of demonstrating the usefulness of onosmodium, but as I have seen nearly all of these symptoms repeatedly relieved during its administration in other cases since that time, I feel quite safe in recommending the drug for the symptoms most prominent in this case, and when prescribed, always anticipate decided success, and, too, after a few doses, as the remedy acts promptly if at all.

Recapitulation.—Constant dull headache, chiefly centred over the left eye and in the left temple; at times so sharp as to be almost unendurable; pain not aggravated by light, noises or use of eyes, but always worse in the dark and lying down; all of which, though somewhat relieved by the use of compound convex cylinders, and the relief to a naso-pharyngeal catarrh, were not cured until three doses of onosmodium tincture had been taken at twelve-hour intervals, the chronic dull pain never returning, and the acute suffering seldom recurring, and always soon relieved after a repetition of the drug.

Although a remedy of great importance, onosmodium has received comparatively little notice; there are few clinical reports, and even Gentry, in his first and second volumes, seems to have neglected it

entirely, judging by his lists of remedies noted at the beginning of each volume. On account of this scarcity of notice, I quote some points bearing upon the case, just recorded, making my selections from Allen's *Handbook*. Under "Head," we read: ". . . *Frontal pain over eyes, worse over l. eye, over bridge of nose, in l. eminence; in r. eminence, changing to l., where it remained; running back into neck; heavy, and the same pain in temples and mastoid region. Pain in l. temple, sharp, darting, in l. temple, darting, throbbing in l. temple . . . Dull, heavy pains in l. side and over l. eye, extending around to back of head and neck, worse from movement and jar, forcing her to go to bed, when they were better after sleep, but returned soon after waking. Occipito-frontal pain in morning on waking. . . . .*"

Under "Clinical:" "Dull headache, worse in occipital region, usually extending down nape or over one side of head, generally; with the headache, usually dizziness, and sometimes nausea, and either preceding or following the headache, pain in or over the corresponding eye, with stiff, strained sensation in the eye, worse reading or near vision. . . . ."

POINTS ON LOCAL TREATMENT.

BY R. W. McCLELLAND, M.D., PITTSBURGH.

Much has been said and written upon the treatment of injuries to the eye, but the subject is of sufficient importance to justify continued and repeated discussion. Such cases are of almost daily occurrence in the experience of the busy practitioner, and the best manner of meeting the difficulty on short notice is a desideratum.

Eye injuries may be roughly classified as follows: 1st. Those produced by blows causing contusions. 2d. Wounds and foreign bodies. 3d. Scalds and burns.

Under the first class we find a greater or less amount of mischief done to the delicate structures of the eye. There may be dislocation of the lens from a violent blow, or rupture of the iris, with effusion of blood into the anterior chamber.

These cases are generally followed by inflammation of a more or less severe type and result in impairment or total loss of vision.

When seen early, much good can be done by the immediate application of compresses saturated with a weak solution of arnica. Where laceration of the soft parts exists, calendula is, of course, to be preferred.

Hamamelis does good service in the early stages of inflammation, but the time-honored and homely poultice still rules where suppuration has supervened. It should be used, however, with care and judgment, as irreparable injury may be done by using too early or continuing too long. A sad example of the ruinous action of the poultice came under observation not long ago. A little girl suffering with conjunctivitis was taken to a physician who advised the use of the slippery elm poultice. This was applied constantly for two or three weeks; in the meantime little attention was paid to its effects on the eye. At the end of this period it was discovered that the delicate tissues had undergone maceration from the prolonged action of heat and moisture, and the eye was a total wreck. The globe now presents an unsightly appearance, disfiguring an otherwise handsome child.

The injuries of the second class—foreign bodies and penetrating wounds—are of more common occurrence. Particles of steel, bits of cinder and other such intruders are frequently met with. To accomplish their removal, *secundum artem*, ofttimes requires the exercise of no little patience and skill. Especially is this true where splinters of steel or particles of glass are found to be imbedded in the cornea or deeper structures. The management of simple cases is familiar to all; an excellent plan is to take a match or large wooden toothpick and taper abruptly to a chisel edge. This will be found much more effective than one which has been brought to a thin edge; by means of the former an object may be easily pushed off, unless it is imbedded. Here it is necessary to resort to such instruments as the cataract knife, needle or rat-toothed forceps. It is imperative that all penetrating objects be removed, even at the expense of considerable cutting; for, as has well been said, "the eye that encloses a foreign body is doomed." The object may be too small for detection, and yet capable of setting up ruinous inflammation. Where it is lodged in the anterior chamber or in the substance of the iris, a corneal flap should be made, and, if necessary, an iridectomy. At times the treatment can only be expectant, with the

use of such means as we have at our command for the control of inflammation. A case will serve to illustrate this point. W. D., æt. 14 years, while watching a workman chip a steel rail, was struck in the eye by a splinter of steel. I saw the boy a few minutes after the accident and found the anterior chamber filled with blood from a wounded iris. I cleansed the parts as well as possible and applied a compress after having instilled atropine. The important question was as to whether the splinter was still lodged in the eye or not.

I was unable to determine this point, and called in my colleague, Dr. Winslow. A careful examination was made, but with negative results. We decided to await developments, but they never came. Cold compresses, saturated in a weak boracic acid solution were applied constantly and a 2-grain solution of atropia instilled twice a day. The eye healed kindly, leaving only the edges of the wounded iris fixed in the corneal cicatrix.

In case of the penetration of large bodies, where the integrity of the eye is not destroyed, we can only remove the body and await inflammation. Some advise immediate enucleation to avoid the danger of sympathetic ophthalmitis.

Some time ago a man was admitted to the hospital with a badly injured eye. On examination, I found and removed a large wedge-shaped piece of metal probably a quarter of an inch square. The question of enucleation arose, but my colleague of the staff advised against it. Suppurative inflammation ensued, which was kept under control by means of hot compresses and poultices, with the exhibition of indicated remedies. As a result, the sound eye remained sound, and a good stump was left for the insertion of an artificial eye.

Where the eye is hopelessly disorganized by a blow or gashed so as to present a sunken appearance, it is good surgery, as well as an act of mercy, to enucleate at once.

In the treatment of injuries, an important point must be decided for each case as to the employment of an astringent or an anodyne. The astringent will result in mischief when not properly indicated, and, in case of doubt, should not be used, especially in recent cases. The anodyne is more frequently indicated and safer. Another important point is as to the use of hot or cold applications. In recent cases of injury, cold should undoubtedly be employed. Prof. Nor-

ton, of New York, testifies that he now saves five cases, where he formerly saved one, by the immediate application of the pounded ice bag. This, he urges, should be kept on constantly until inflammation either appears or is prevented.

The third and last class of injuries comprise burns and scalds, the destructive agents being usually hot water, slaked lime, molten metal or acids.

Among mill-workers we have the unfortunate and all too frequent splash of hot metal. In almost any mill may be seen a score or more of men with eyes disfigured, or, perhaps, sight obliterated, by this accident. The best treatment for burns is the immediate instillation of a little sweet oil, or, in the case of lime, a little warm milk, followed by the oil, removing, of course, any particles that may remain. Afterwards treat for inflammation.

Cicatricial contractions and symblepharon are the usual sequels, and form a most stubborn and troublesome class of cases to treat. The supreme moment in the treatment of burns is immediately after the accident has occurred. Whatever is done in the way of effective treatment must be done then, for, as a rule, when the physician reaches the case the mischief is done.

A large percentage of cases might be saved by promptness, and a knowledge of the simple means to be employed should be a part of the education of every child.

REPORT OF THE BUREAU OF PÆDOLOGY.

"Catarrh in Children," by P. S. Duff, M.D.

"Psoriasis in Children," by James H. Closson, M.D.

"On the Importance of Early Treatment of Children's Diseases," by A. P. Bowie, M.D.

CATARRH IN CHILDREN.

BY P. S. DUFF, M.D., GREAT BELT.

I CHOOSE catarrh as the subject of my paper not because it is the most fatal disease of infancy, but because it is the most universal,

the most insidious in its approaches; the most neglected and the least thought of. "Get used to it." It is so with the tippler, dram-drinker and inebriate, and all who habituate themselves to imbibe stimulants, as alcohol, tea, coffee, tobacco and narcotics. The slave gets used to his master. Nor did I think that the taking of colds and diseases arising therefrom would be so difficult and exhaustive to learnedly grasp, handle and cull into one conclusive, limited paper.

Catarrh Defined.—The term is derived from a Greek word, meaning "to flow down," and is the result of an acute inflammation of any mucous membrane arresting and changing the moist secretions found in these membranes to a dry, tumid condition, they becoming redder than their natural color.

The ætiology or causes of catarrh can scarcely be enumerated. Its most common seat is in the nose, the nasal mucous membrane, it being more exposed to external influences than others. All mucous membranes are liable to be invaded when the field (organ or part) is prepared, *i.e.*, the life powers weakened and seed sown. Catarrh may be ante- or pre-natal. Sins of parents may extend to child in utero. If the mother be a catarrhal subject, the offspring inherits coryza. Maybe a tender infant is ushered into a cold, damp, dusty, "dead-air" room. By far the greater majority of children's diseases are caused by catarrhs unlimited in their destructive processes. Invariably they seek the weakest part—its future stronghold for serious trouble. We find this point verified in injuries and wounds and irritations of mucous membranes anywhere—throat, stomach, intestines, sexual and urinary organs—after exposure, insidious or otherwise. Whatever disturbs the equilibrium of life's forces, as changeable climate, close apartments, a much higher temperature than in the outside air, are fruitful causes of nasal and bronchial catarrhs.

Acute catarrh might unawares vacate, leaving the parties concerned no wiser, were it not for the abuse of the too-frequent taking of improper and inappropriate food, and the deprivation, externally and internally, of the invaluable therapeutic agent, pure water (temperance with a vengeance), and the narcotics that are selfishly kept in stock and given with a will, thus stupefying into quiescence, (no cry or dread of danger), and sooner or later the soothing-to-death drug within covers or deludes the senses of patients to evil (if

it does not mothers and attendants) to the deaths of maimed, cripples, idiots and insane, drunkards and paupers. Parents and guardians, by their shortcomings, are liable for the ills and sufferings inherited, as a natural consequence, from the wrongs done those under their charge, and the result—unsound constitutions.

The membranes are more delicate in the young infant, and resist inefficiently the various noxious influences resulting from their environments. If the child is born sound, it may hold out for a few weeks or months before the membranes weaken or result in inflammation or catarrh. The nose, intended for breathing, needs to be used for breathing, or disease results, hence the necessity of keeping that organ in normal action before serious obstruction or disease gets a firm hold. Infants are more liable to catarrh until the teeth are through. The teeth are to be used to masticate food, and ought to be properly used, or decay and disorder will set in. From bad teeth and gums, so disgustingly offensive, chronic catarrh will spring. Functional disturbance of the digestive organs are also causes of catarrh. The normal gastric secretions are apt to destroy the action of the disturbing germs. Stomach and intestinal catarrh from carbonic acid, adulterated air, tainted food, as fish, bread, milk, indigestible irritants, skins and seeds, unripe food, particularly what has sickened before, and any substance that acts as an agent causing inflammation, are also to be noted in the ætiology. The patient takes cold easily after exposure, from poisonous air in a heated or confined room. The cold air, *contrari contrealis*, drives germs through the system to fasten themselves on the weakest part; hence, we diagnose catarrh of the part infected. An erythematous inflammation, pharyngeal, is brought on, and kept up by a cold upon a cold. Pollen fur from leaves wafted by the air, carpet and house dust, uncleanliness from lack of proper bathing, unsanitary clothing, unsuitable material (too short, exposing wrists and ankles), rapid transit from one place to another (cold or warm), cold, by way of the unprotected spinal column, are all causative factors.

It is a mystery so many of the angels of the household survive; the odds of dangers are against them after their luck in seeing the light of day.

Taking cold, with its endless variety of grafts, and looked at from the standpoint of to-day, is truly appalling. There are more causes,

which it would become irksome to note. Dry air; atmosphere dry and parched; mist and night dews in the morning; close, heated apartments, from natural gas, etc.

The symptoms are various, depending upon the degree of the inflammation and its stage, as depression, chilliness, languor, loss of appetite, the nose runs water, the nose stopped up, sneezing, pain in suffering part, cough, some difficulty in breathing, wheezing, hoarseness; the mucous secretions are arrested and the bloodvessels and lymphatics over-distended, so that a discharge, more or less acrid, acid and excoriating, is established. In the ordinary course of catarrh, particularly when homœopathically treated, the discharge thickens, becoming more normal and consistent, the swelling diminishing, mucous membranes becoming less raw and irritable—grades to convalescence. Unhappily, catarrhs do not end so favorably, nor do they limit their insidious progress, but ever seek the weakened membranes. From the nasal mucous membrane, following the tract of the eustachian tube to the middle ear, causing otitis media, deafness, suppuration and destruction of both the soft and hard parts or tissues, chronic thickening of the mucous membrane, etc., becoming more serious as it extends to the tonsils, larynx, trachea, bronchi, pharynx and lungs, intestines, urinary and genital tracts.

In preparing my paper I approach the common law, twenty-one years old, but I feel that I am limited to pædology. Scarcely a weak or exhausted organ or part is exempt from cold taking; teeth, joints and articulations, large and small, causing pleuritic-like stitches. The experienced can only know the seriousness of a "cold:" feet, ankles, hands or wrists, back (when in latter look for catarrh in lower extremities, as sciatica) and in the hip-joint, particularly after being heated, etc., followed by a cold, change, etc. Uncommon symptoms and parts affected call for the similar remedy, be the diagnosis what it may, as, for instance, rhus toxicodendron after cessation of exhausting labor, hot, a cold change, sciatica, lumbago, crick in back, are rhus toxicodendron indications.

In chronic nasal suffocative catarrh, the child cannot take its breast milk; it strangles, is angered and breathes only through the wide-open mouth (insects can go in). In some cases, cyanosis and spasms occur.

Acute catarrh of the stomach denotes those children one year old

who are confined to milk. In its highest grade it is a most dangerous disease of childhood. Cause: bad milk or too old; given improperly and too often, as every time child cries (for a purpose), the woman menstruating, sick or severe disturbance of the organism. Milk is, *par excellence*, a child's food. Solids are not indicated until the first four teeth are through, then a mixed food, easy of digestion can be used. The child vomits milk not curdled, and mucus after; the mouth and lips are pale, the patient is restless, the stomach is bloated and sensitive, the child draws up its legs and cries after food; the skin is hot and less elastic; the bowels are loose, yellow, green or brownish in color and may be undigested, like stirred eggs, and the odor sour or fetid. In older children any cause, as irritant or indigestible substances, that will have a tendency to weaken the mucous membranes of stomach or alimentary tract, starting inflammation marked by severe, sharp, cutting, excruciating, penetrating, tensive pains and catarrhal discharges, at first free and abundant, with a few moments' relief after a stool or vomiting, which will recur again and again until disease has run its course, can be a factor. When this form is established fully, the remedies need to be repeated often, as every ten or twenty minutes to one and two hours. If the child is old enough, lukewarm water given is cleansing to the stomach, and is the first and best treatment.

Already has my paper become too lengthy and more could be said; and yet the main, the most important, the therapeutic agents, the very soul of Homœopathy, has to be spoken of; yet I fear I would be overleaping my bounds and a trying ordeal on your patience, to have all the drugs and their curative range in catarrh given, therefore I shall make it as short as possible, and kindly request you to work, with the resources you are blessed with—find the true similia and be crowned with a cure.

A few remarks on diagnosis first. Noting the symptoms present and their location and the ætiology in catarrh or coryza, concerned parties need not be deceived. If the chill, etc., has not occurred, a swollen appearance of the face, congestion and heaviness, redness and lachrymation of the eyes, as usually present, are confirmatory evidences. When other localities are affected, fever, congestion and pain characterize them, the patient feeling uncomfortable and sensitive generally.

The prognosis of catarrh or cold, in its usual acceptance, is not grave, leaving out those severe cases aggravated by frequent relapses from improper care and treatment, progressing to the bronchi, lungs, eyes, ears, etc., producing acute and chronic inflammation of the attacked part, becoming more serious after each attack.

It is a work of first importance to arrest an acute catarrh in its incipiency. This would strike the root of a greater portion of our chronic pulmonary diseases and also of other organs, as eye, ear, uterus, etc. Much poor health and mortality would be saved the community if acute catarrh were learnedly and successfully treated, it being much more readily cured than chronic catarrh. Hence, for the former, the "stitch in time, or the ounce of prevention," should be given. The true physician can both prevent and cut short diseases that are remotely death-dealing, as well as those that are quick and proximate. To the first of these classes belongs acute catarrh, too often neglected or injudiciously tampered with—"gave castoria," "a bottle of cough syrup, teas of catnip, drank chamomile tea and greased the breast well with goose fat." In a case of capillary bronchitis in an infant far spent, but which I had hopes for, I yielded to the oiling habit, retired, and the patient was dead in an hour. "I'll just let it take its course," is a common expression, and many are brought to this heroic state by dominant parties or self esteem. As an example of the latter I cite the following: An unacclimated fortune-seeking Californian returned to his Eastern home. When solicited to take medicine for a severe cold, he said, "I would not doctor, nor take anything for a cold; I can knock it out." Repeated colds afterwards caused him to feel quite anxious to get cured of a chronic catarrh, then his master.

Therapeutic Treatment.—The drugs that are Homœopathic will compare with the tiny seed disease germ which produced the educated tree disease-symptoms held fast by rootlets; it grew, branched; buds, leaves, flowers and fruit result; symptoms, bad tree, bad fruit. A man wielding an ax with a strong arm can cut it down. The roots will not yield their possessions: a changed taxis and fiercer mode of attack must be brought against them—though accomplished, a mark will remain. The educated drug, homœopathically prepared, with similar characteristic symptoms, is

the right man with the right implements in catarrhal as well as all other diseases.

Camphora at the first attack, marked by chilliness, depression and languor, will stop further progress. Given, one or two doses, low, will suffice. Later, in the febrile stage, camphora will be the wrong man in the wrong place.

Aconite is mostly the next best acquaintance. Fever, hot skin, mental anxiety, restlessness, coming on from dry cold air, headache, roaring in the ears (headache may come from suppressed coryza), aggravated in confined air and from talking, etc. In severe cases there may be burning, pricking and hoarseness in the eustachian tubes. In the incipient stages it is the first remedy in catarrhal or inflammatory conditions of the air-passages, especially febrile forms. Mostly the trouble will cease or be cut short by this medicine. It is indicated in dry or moist coughs. Relief generally comes soon. If not, go to the deeper dipping remedies.

Allium cepa.—Thin watery discharge, dropping from the nose, acrid, excoriating the upper lip; sneezing, weeping, smarting, biting, irritating the eyes to active flow of non-acrid tears. The cough, which is dry and hoarse, seems to start from tickling behind the pomen Adamii, which is peculiarly sensitive and painful. Cepa's action is most marked on the nose, eyes and larynx. Stomach—continual eructation of gas, nausea and pressure.

Antimonium tartaricum.—Pale face variety; puffed or bluish; cold sweat on the forehead; difficulty of breathing from much mucus in trachea and bronchial tubes, nose obstructed; aggravated about three o'clock, A.M., has to sit up in bed; ameliorated by coughing and expectorating; gasps for air before every attack of coughing; yawning, profuse lachrymation and vomiting; child wishes to be continually carried; when touched utters piercing cries; ulcerated nostrils, violent fluent coryza, asphyxia; cough in teething child, râles can be heard at a distance, disappearing when coughing bout is over.

Argentum nitricum.—Patient is constantly chilly; lachrymation and sneezing; acute pain above the eyes. Patient reclines, lying from debility, more in legs; the throat, tonsils and uvula are sore with rattling of phlegm in the larynx until hawked up in lumps; when the eyes and head are involved the sense of smell is blunted and small ulcers appear in the nose, with discharge of purulent matter;

trachea is sore from coughing. This remedy suits dry catarrh, which grows moist later; rattling cough, profuse sweat and thick yellowish expectoration; pallid, sunken, old-looking face in acute and chronic catarrh. Patient craves sweets and cheese; aggravated from sours, coffee drinking at night, and in wet weather.

Arsenicum Album.—Discharge of a burning, watery mucus (first fluent, later nose stopped) from the right nostril; all the secretions aggravated from cold (except headache), dampness, or night air, or after midnight, has to sit up; coughing, amelioration by warmth; chilly, loves to be near and cling to the fire; pains are accompanied by restless anguish and desire to change place; thirst, a little satisfies, wanted often; chronic cases, malarial miasm; poorly nourished from faults of assimilation; exhausted; tendency to catarrh.

Belladonna.—In simple catarrhs, inflammatory kinds of any or all mucous membranes of the larynx, trachea, on to the lungs, especially the first stage, and capillary bronchitis; patient nervous and sensitive.

Bryonia Alba.—Fluent coryza; violent sneezing; stitching headache on stooping; chronic, extending to chest, with stitches; stiffness of neck and pain in nape; worse on motion; sweat from least exertion; cough is of the concussive kind, coming from the sternal region, as if the chest would burst. Bryonia is, above all, the loosening remedy in the second stage, after aconite or mercury. It is the principal remedy in bronchial affections of various kinds; cough is worse coming from cold air to warm room, and after eating and drinking; patient desires to lie down and be quiet; thirst for much, not often; storms and east winds aggravate; irritable disposition; patient has nausea and vomiting, especially after food; dyspnœa.

Carbo Vegetabilis.—Crawling, tickling in nose; sneezing, and ineffectual attempts at sneezing; chronic hoarseness and raw chest; itching in the trachea and chest, worse when coughing; subject to epistaxis; aggravated from 4 to 6 o'clock P.M.; going into cold air, takes cold easily; after eating and drinking, soreness of chest and heat of body when coughing.

Calcarea Carbonica is first to be thought of in defective assimilation and nutritive derangements, marked by rachitis, scrofula and tuberculosis; patient very susceptible to external influences, as currents of air, cold, heat, noise and excitement; patient grows fat;

sweats profusely, especially the head; the nose dry; the coughs of calcarea have an organic basis, and it is one of our best antipsorics; feet sweats and are damp; milk disagrees; the remedy is often called for in catarrhs which run on into structural degradation simulating phthisis. It is also a good remedy in scrofulous ozœna.

Chamomilla.—The child is quieted and relieved by carrying it briskly; one cheek red, other pale; watery or mucous discharge from the nose, viscid, causing redness; child appears to want and don't want things; over-sensitive, inflamed lower eyelids; otalgia, with stitching, tearing pain; swelling of parotid gland; inflamed tonsils and soft palate, with dark redness; hoarse cough at night, even in sleep; worse in dry weather, evening and when still.

Dulcamara is adapted to nasal catarrhs and influenzas of the fall. Every exposure renews catarrhs, as wet weather, getting wet, cold, damp and open air, at night; coryza; dry, hot skin; limbs numb and cold; muscles of the neck and back sore and stiff; offensive sweat; much sneezing, and buzzing in the ears; earache; urticaria; ameliorated in closed room.

Eupatorium Perfoliatum.—Influenza, with much prostration; pulse weak; bones feel as if broken, sore; throat dry and sore; patient restless, cannot keep still, yet motion don't relieve; aggravated from 7 to 9 o'clock A.M.; prevents the colds from wet weather.

Euphrasia.—Violent, fluent coryza, with smarting burning in nose, aggravated by inhaling cold air, tobacco smoke; scalding tears, corroding and excoriating eyes, sensitive to light; lids swollen; discharge bland; conjunctiva injected; coryza, with difficult expectoration, better from eating; vomiting mucus; difficult respiration, at times gummous secretion from eyes and lids; traumatic catarrh.

Gelsemium.—For spring and summer catarrhs look gelsemium up; also in catarrhs of the eustachian tubes; in bland, not purulent, watery catarrh of nose, ears or eyes; all symptoms worse at night; spasms; threatened suffocation; prostration of whole nervous and muscular systems. In stomach and intestinal catarrhs from indigestibles, as skins of cherries, etc., or substances that cause oppression; in children and adults whose healths are feeble, and who are consequently exposed to frequent and severe catarrhal troubles; hard cough, with inability to expectorate; has to hawk and blow nose; pain

in head and back, worse in right side; sensitive to cold air; great general fatigue.

Hydrastis Canadensis.—Right nostril excoriated; discharge scanty in close air, profuse out-doors; throat and chest raw; the air feels cold when inhaled; inclined to blow the nose constantly; secretions mostly from the posterior nares; mucus becomes thick and tenacious, drops down into the throat from posterior nares continually; much hawking to clear the throat. Hydrastis increases the secretions of the mucous membranes; tenacious, ropy, often corrosive, discharges. In gastric catarrh the bowels are sluggish, and there is a gone feeling at the stomach or faintness.

Kali Bichromicum.—Suitable for catarrhs which prominently affect the throat and stomach. The secretions of kali bichromicum are ropy, tenacious, string out into long threads. In colds that are worse in the summer, and in fat, light-haired people. It has a wide range of application in catarrhs involving nearly the whole respiratory tract, as well as ears and stomach. *Inflammatory redness of the pharynx and fauces,* with a smooth or papular surface, are characteristic of kali bichromicum.

Lachesis.—Malignant catarrh; throat and fauces and neighboring glands much swollen; even the kidneys become so much involved as to eliminate albumen instead of the normal urinary products. Infectious catarrhs, first left side; plastic exudation on the tonsils and along pharynx toward the right side. Much sensitiveness of the neck and throat. It is useful in non-infectious spring catarrhs and where the mucous membranes are swollen, look blue and the parts are very tender, and where the nose is filled with scabs and bloody pus oozes from the nostrils. Cough is aggravated by pressure on the neck, after *sleep* and after eating; perspiration has strong smell, like garlic.

Lycopodium.—Suits patients who are apt to take cold easily and have derangements of the alimentary tract (one greatest cause is the eating of pastry, dough nearly raw—abominable makeshifts); flatulent; false hunger, a few bites fills. Lycopodium acts on the mucous membranes, skin and respiratory tract. The remedy has also acute smell; pain pressing inwards in temples; nares dry, scurf in the nose, followed by acrid discharge or plugs; the cough is dry, seemingly comes from the stomach, which is painful, aggravated from

lying on left side, eating or drinking cold things, wind or warm room; voice hoarse, feeble and husky; trachea dry; patient wants the open air; fan-like motion of the alæ nasi; the disease moves from right to left, as well as the pains. Lycopodium is important in catarrhs of the bronchi, which are likely to ulcerate or simulate phthisis, and adapted to persons of attenuated muscles and keen intellect, who are subject to pulmonary and hepatic affections and right-sided catarrhs.

Mercurius corrosivus.—Fluent coryza, much sneezing, the mucus excoriates alæ and columni nasi; aggravated in damp weather, nights, from cold and warm air, especially when getting warm in bed; head feels as if growing larger and larger, feels full as if bursting; feeling hot and cold; fluency, especially if it involves the salivary glands.

Mercurius solubilis.—Catarrhal coughs of an inflammatory organic nature; running from fauces through the trachea and down to finest bronchial divisions. Useful in acute and chronic catarrhs; rough, burning, sore feeling from fauces down to sternum; hoarse dry cough, raw, concussive, exhausting; sputum watery, nasty, bloody. Mercurius solubilis is the sovereign remedy for inflammatory bronchial catarrhs.

Nux vomica.—Patient takes cold easily from a draught, in the head from dry wind; oversensitive to all kinds of impressions; inveterate fluent coryza by day, dry at night, worse in a dry room, better in cold air; chill, even by the fire, and after drinking; wants to be covered in the fever stage; frontal headache with constipation; irritable; wakes at 3 o'clock, poor sleep and rest afterwards; frontal cavities more often the seat of the catarrh; fauces and pharyngeal mucous membrane is principally affected. Hence the cough of nux is grating, scraping, rough, dry; irritation in the throat or above sternum, inveterate coryza; influenza, more particularly in simple catarrhs and where spinal irritation causes cough; ameliorated by warm drinks; aggravations by cold, by eating and by mental exertion, are conditions which constitute the sphere of nux.

Natrum sulphuricum and nitric acid need a thought in many catarrhal cases.

Nitric acid.—Has a yellow, fœtid discharge from the nose, œzenas with ulcers; mercurial and syphilitic complications; eustachian

tubes obstructed or purulent at otorrhœa. Its action is most marked on the mucous membranes at the outlet of the body; eyelids swollen and livid; gets choked when eating; catarrhal cough returning every winter.

Pulsatilla.—Patient is tearful; has blue eyes; mild disposition; symptoms changeful; coryza fluid or dry; nostrils sore, with loss of smell; alternate stoppage and running of the nose; coryza worse evening, ends with a yellowish discharge; cough loose by day, and at night lying down a dry, tickling cough, when there are mucous râles; where asthmatic difficulties arise from the accumulation of mucus (emphysema, catarrhal inflammation in the throat); better out of doors; worse in the evening and night; stomach disturbed, mostly from fat, rich food, strong milk; fever; no thirst; coughs from getting hair cut, the head or feet wet; otalgia, with darting, stinging pains, with discharge of pus evening and night. Pulsatilla, like hepar, is only appropriate in the loose cough, with expectoration of much mucus, yellowish-whitish, salty, and at the end of the catarrh, and in chronic catarrhs.

Podophyllum.—Mucous membrane irritated, especially that of the small intestines, inflamed (also the bladder) and congested; micturition painful; very red urine.

Rhus Toxicodendron.—Catarrhs after severe wetting with rain, when heated, worse when quiet, before a storm, in damp weather.

Rumex Crispus.—Nightly aggravation of symptoms; child is annoyed and awakened from sleep by catarrhal cough; the nose may be obstructed or running, aggravated by cold air; wants warm air; cough hoarse and barking, comes on in the night, 11 P.M. or 2 or 3 A.M., wakes patient. Apis patient coughs and sleeps on. Rumex patients are worse from cold changes, raw winds, dampness, the slightest inhalation of cold air; wants to cover head to make the air warm.

Sambucus.—Snuffles of children; nose stopped; can only breathe through the mouth; mucus keeps up a rattling sound in the chest; the cough is dry and hollow-sounding; child awakes at 11 o'clock P.M.; suffocating spasms, passing off to return sooner or later.

Sanguinaria.—Much soreness in the roof of the mouth, extending to the pharynx; right side of throat, even down to lungs, feels as if scalded or burnt; particularly with this burnt feeling there is

rheumatic soreness of the muscles of the palate; much dryness down air-passages; loss of taste and smell; the cough of sanguinaria is constant, dry, hacking, from tickling behind the sternum, awakening the patient from sleep; where there are irritations and inflammations of mucous membranes of the air-passages and stomach, extending from these to pneumogastric; deranged liver and digestive tract; there is smarting and soreness in the left lung; useful in bronchial catarrhal coughs, where the passing of flatus up or down relieves; also in migraineous subjects and their catarrhs of torpid livers or diarrhœas that follow a cold.

Sepia is well suited to persons with dark or blonde hair, who have sallow complexions, particularly females, and for the catarrhs associated with uterine derangements. Dark brown, offensive urine; loss of smell, or fœtid odor coming from the nose; large lumps of yellow-green mucus at times blown from the inflamed and swollen nose; ulcers high up in nasal fossæ; cough short, dry, usually by day; tuberculosis; in chronic catarrh, especially if complicated with chronic gastric catarrh.

Sulphur.—Useful in acute and chronic coughs, catarrhs and inflammations, particularly when there is a dyscrasic element in question, to awaken reaction and resolve hepatization; in nasal catarrhs; not so much called for as in bronchial and tracheal, with the symptoms characteristic of pulmonary diseases; catarrhal symptoms, with cough, gets worse in the morning, or suppressed cough; patient wants doors and windows open; dislikes the bath; constipation, with dry cough and emaciation, the stomach rejecting food; morning diarrhœa; feels faint at 10 A.M., and must eat. Sulphur (not unlike other remedies) needs to be looked up and given in time to allay constitutional taint and prevent incurable pulmonary diseases.

This list does not include all the therapeutic remedies that may be called for in cases of diseases arising from acute and chronic catarrhs; but my paper, I fear, is too lengthy, and materia medica will richly repay the looking up of similar symptoms.

PSORIASIS IN CHILDREN.

BY JAMES H. CLOSSON, M.D., GERMANTOWN, PHILADELPHIA.

As it is generally acknowledged that psoriasis rarely affects children, I feel that no apology is necessary in using the above title for this paper, and occupying the attention of this Society with so trivial a matter as the report of three cases of this affection cured by remedies prescribed Homœopathically.

It is not the purpose, in a short paper of this character, to enter upon the lengthy ætiology or history of psoriasis, but in a manner, as clearly and concisely as possible, give such results as have been obtained in these three cases by the careful selection of the proper remedy.

Psoriasis is a disease of the skin, due to the excessive accumulation of epidermic scales, appearing at first in spots the size of a pinhead, in color whitish, and heaped one upon the other, being loosened from their connection with the cutis.

Beneath these whitish scabs or crusts the patches are of variable size, slightly elevated, reddish, rough, and bleeding easily. After several days from its first appearance, these patches increase in size, sometimes slowly, sometimes rapidly, and, by this extension and union, larger, irregular-shaped patches are produced. At this early stage of the disease there may be some troublesome itching, therefore scratching, which may change the scales into black scabs or crusts.

As the disease progresses, the epidermic scales, becoming loosened, fall off, leaving exposed the slightly elevated reddish-, brownish- or copperish-colored spots. Sometimes, however, there may be but partial desquamation; in other cases the patches may become inflamed, and the scaly surface exude a secretion closely resembling an eczematous eruption. The most frequent seats for the affection are found to be the elbow, knees, forehead, hairy scalp and back.

Psoriasis is a chronic disease, always subject to relapse, affecting patients who are otherwise, apparently, in the best of health. It is often attributable to gastric disorders; frequently to damp atmos-

phere; articles of diet; rickets; catching cold; tuberculosis; uncleanliness; and drinking cold water when heated. It is sometimes said to be hereditary, nearly always in the sanguino-bilious temperament, and prevailing between twelve and thirty years of age.

Homœopathy may often succeed in the treatment of this affection if we are careful to study the symptoms of the patient and adhere closely to our remedies, remembering, however, to view the disease in its totality. There are several drugs that appear to have distinct curative remedial effects in the treatment of psoriasis, but it is not our intention to enumerate all, but simply those few that have given the best results in our hands, namely, arsenicum, phosphorus, cantharides, sepia and ferrum; and how admirably some of them have acted when properly selected, the following cases will fully illustrate:

Case 1.—John R——, æt. 6 years, born of healthy parents and free from scrofulous or syphilitic taint, was presented to me for treatment August 16, 1889, up to which time he had been under the care of several physicians, who had exhausted their stock of local applications without avail. I at once determined to employ the single remedy prescribed in accordance with the law of similars. On inspection, I found the skin of the greater portion of the back, and a small portion of the chest, affected with psoriasis, and sharply marked off against the healthy surrounding tissue.

There was considerable burning and itching; the skin dry and very scaly; the crusts, in places, were blackened from scratching; extreme restlessness in the early morning; fearful dreams; excessive thirst; involuntary diarrhœa; sickness at the stomach; at times violent retching, but no vomiting; tongue very red, and covered with painful blisters. There were many other symptoms present, but these had been apparent for quite awhile. Arsenicum 6x was prescribed, and, in conjunction, tar soap was recommended for the bath; and it was also advised that cod-liver oil be administered in quantity just sufficient to be retained. The effect of this treatment was remarkable, improvement was noticeable at once, and in two months' time he was pronounced cured; and from that time until the present day there has been no return of the trouble.

Case 2.—W. M., a little girl, æt. 8 years, came under my care in July, 1890. Every practicing physician occasionally meets with

cutaneous disease of long duration, and undoubtedly presenting the most stubborn resistance to all therapeutic efforts. This case belonged to that class, rebelling against all medication, both internal and external, even chrysarobin and pyrogallic acid proving of no avail. Being extremely anxious to effect a cure for selfish reasons, I determined to make a more thorough study of the symptomatology, and, not being able to discover any remedy in our materia medica, which, in its pathogenetic efforts, more closely resembled this individual case, than phosphorus, it was prescribed in the 3x, with the most happy results, the patient progressing until a cure was effected in three weeks from the date of the first prescription.

Case 3.—G. K., æt. 5 years, brought to the dermatological clinic at the Children's Homœopathic Hospital, August 12, 1890, having been pronounced by an experienced physician to be a most difficult and stubborn case, promptly yielded to the Homœopathic remedy carefully selected in accordance with the totality of the symptoms within twenty days, cantharides 3x having been prescribed.

ON THE IMPORTANCE OF THE EARLY TREATMENT OF CHILDREN'S DISEASES.

BY A. P. BOWIE, M.D., UNIONTOWN.

Children's diseases constitute a large share of a physician's practice, and by some it has been estimated that one-half of the cases we are called to treat belong to the domain of pædology.

When we realize this fact, and the great importance of thoroughly understanding this department of medicine, then will we be better able to cope with the diseases incident to childhood. To save the babies—those dear household treasures—what more important matter can engage our attention, and yet it has seemed to me that oftener than any other class of complaints are they neglected, not that they are not cared for and treated after a fashion, but proper care and attention in the curable or preventive stage of their diseases is not commenced soon enough.

Homœopathy has an established reputation in children's diseases, and by some families it is only the children we are called upon to treat, and thereby we are given the best testimony that can be bestowed upon us, for he who best treats children's diseases can be called master of his art, for the obstacles in the way of treating children are many, and the results of treatment are very apparent; for who has not heard it said: "The child is so young it is hard to tell, or you cannot tell, what is the matter with the child?"

Now, to get the best results in treating children, it is very necessary and important that treatment be commenced early.

I am not one of those who believe that disease "has to run a course," or that you cannot arrest disease in its early stages. Experience teaches better.

A wise and careful treatment of disease in its incipiency gives best results in any disease. No physician will gainsay this, and yet every day we practice we see evidence of neglecting the early stage of disease by parents, because they thought the child was not sick enough to call in a doctor.

Is it not, then, our duty to instruct parents and guardians to call us early, and not neglect precious and valuable time in administering so-called home treatment; "only simples," as they are called, teas, castor oil, paregoric, soothing syrup, plasters and lotions, and such like abominations. Even ordinary Homœopathic treatment with our domestic books and remedies should only be used until a physician can be obtained, for if it is hard for a doctor to tell what ails a child, how much harder for a parent to prescribe accurately; and yet I would not have intelligent people without a few well-chosen remedies to be used in emergencies, for the "box and book" have not only power to be good missionaries in the propagation of the true medical faith, but are valuable aids to the physician and patient.

Physicians should be educators as well as practitioners, and we should take every opportunity to tell our patients to call us early in the beginnings of disease, and not when the last stages have been reached.

Some one has said we need to be called in before the child is born, and this is very true, for proper treatment with our deeper-acting remedies will remove many depressive and disease tendencies when

given to the mother, for we have the testimony of the best pathologists that the "unborn babe" is subject to disease, and why is it not susceptible to treatment?

Another relic of old-schoolism is believed by many mothers, and which prevents them from taking remedies during pregnancy, is that it is unsafe to take medicine during that time, for there is danger of abortion. But while it is true of the class of remedies and doses usually given by Allopaths, it does not apply to Homœopathic medication, for what does our own Guernsey say?

After mentioning the results of Allopathic medication, he says: "Contrast with this the fine, healthy child born after the mother has been relieved of her distressing disorders of pregnancy, and, in a great measure, at the same time cleansed of her constitutional impurities by Homœopathic medication, and you have a picture of what has been done in thousands of cases, and of what it is now the duty of the Homœopathic physician at least to attempt to do in every case of the kind.

"He is the true physician who seeks not only to relieve present suffering, but at the same time to remove its cause in the constitution itself, and thus prevent a return of the evil. He is truly a benefactor of his kind who, not content with curing the generations with whose successive potions he mingles, thus seeks to improve his present opportunities in the light of an advanced and beneficent science, in such a manner that the race may be rendered healthy in all the years to come."

Such words as these, coming, as they do from one whom we all revere, and whose experience was such that he could speak with authority, should spur us to endeavor to accomplish the results he mentions, and our patients should be told that we are able to do such things, for in many cases we are not called in to treat pregnant women, and thus we lose the golden opportunity to do good to them and their children.

The future health of the human race is largely in the hands of doctors, and we should not fail to use every means in our power to improve, not only the health of our patients, but of their offspring.

Years ago, Dr. Lippe, writing on tumors, said that such growths were unknown in those who had always had Homœopathic treatment, and recently Dr. Gallavardin advises remedies to prevent the

alcoholic appetite from developing. With the wealth of mental symptoms in our materia medica, may we not be able to change the character and disposition of children, and thus aid in regenerating the world and correcting the evils resulting from bad organization. Our materia medica is a great mine—all it wants is to be well worked to reveal its hidden treasures. The organism needs to be studied with it, for it is our compass, and neither can be dispensed with if we want to be masters of the healing art.

This much for the earlier period in a child's life. When the babe is born there commences the real battle of life, and disease is ready to attack the frail form, and our first duty is preventive. *Save the child from dosing*—keep away the teas our grandmother used and make known to all interested in the child's welfare that now the foundation is laid for future health or disease. Let them choose. It is the physician's duty to be particular and minute in regard to the care of the child, regarding its bath, food and clothing, its sleep, the air it should breathe, and everything pertaining to the hygiene of the babe, and thus a host of troubles incident to the young life can be prevented by timely counsel and advice. Take nothing for granted. Even professional nurses need to be advised, and you should see that they carry out your instructions.

It is the stitch in time that saves. Leave nothing undone that will add to the comfort of the child or mother.

But alas for our learning! Well has Bach said, upon the attention given to such minutiæ as this our success depends; but how often are our best rules violated, and some learned(?) unprofessional who "knows all about babies" steps in and says what is directly contrary to our advice. It is only the doctor who knows how many doctors there are in the world. Most everybody gives advice, and like a good many other things that are gratis, it is only worth what it costs.

If there is any reason to suspect the child to have any hereditary dyscrasia, antipsoric prophylactic treatment should be given according to the plan of Dr. Gastier, of Paris, as detailed in Dr. Leadan's work. This will be especially necessary where we have not had charge of the mother before childbirth.

This treatment consists in administering to the infant soon after birth, two globules of a high dynamization of sulphur, to be fol-

lowed by calcarea, each remedy to act for several weeks. Other remedies may be given in the same manner, and I can bear testimony to their value. Where this treatment is thoroughly carried out without any interference, acute diseases in children are not as frequent; or when they occur, are not so violent.

A large part of the affections of childhood are acute, and they should be promptly treated and not allowed to become chronic, and when acute infectious diseases are prevailing, preventive remedies should be used, as belladonna for scarlet fever, pulsatilla for measles, etc.

But the object of this paper will be accomplished if I have succeeded in impressing the important truth—that at the beginning of diseases is the time to commence the treatment of the diseases of childhood, and we are never to neglect the ounces of prevention.

REPORT OF THE BUREAU OF SANITARY SCIENCE.

"The Air We Breathe," by J. F. Cooper, M.D.
"The Hygiene of the Alimentary Canal," by M. S. Williamson, M.D.
"Fallacious House Drainage," by John C. Morgan, M.D.

THE AIR WE BREATHE, ITS CONSTITUENTS, AND THE BOUNDARIES WITHIN WHICH LIFE AND HEALTH CAN BE MAINTAINED.

BY J. F. COOPER, M.D., ALLEGHENY.

An atmosphere is necessary to maintain life. Without an atmosphere of proper composition the entire animal creation not dependent upon water as its source of life-sustaining elements would perish and hasten to decay. Its elements and their proportions are so admirably adjusted to the wants and well-being of all animal life above water, that when in proper hygienic condition the most perfect health

and development are seen. Without it, man and the inferior animal creation dependent upon it would be in vain.

From the elements that enter into and become important parts in vegetable growth, an atmosphere properly constructed seems as necessary for their health and development as for man. At every point where animal and vegetable life are maintained in any degree of perfection there is a uniformity in atmospheric proportions that testifies of design and of the skill of a creating power. The difference in the elements of our atmosphere on sea or land, on plain or mountain-top, is so small that it would seem almost impossible to have it adjusted so nearly alike in every place, but such is the fact; and where no disturbing influence is seen, a healthy growth and perfect development are a natural consequence. The atmosphere surrounding our earth is evidently of considerable height, variously estimated at from one hundred to two hundred miles. At the ocean level it has a weight of fifteen pounds to the square inch. A column of air the whole height of the atmosphere is equal to a column of water of the same thickness and thirty-four feet in height. The atmospheric pressure decreases in just proportion in weight and density as an ascent is made from ocean to uplands and high mountains. So far as known, a uniformity exists in the proportion and admixture of its elements. Two primary gases form the greatest proportion of its bulk. And two other gases are found in small proportion more or less constantly forming a part of its volume. Nitrogen constitutes the largest element, and in a hundred parts by measure claims 78 and $\frac{98}{100}$ parts as its proportion. Oxygen, the real life-sustaining element, is measured at 20 and $\frac{99}{100}$ parts. Carbonic acid is represented by $\frac{3}{100}$ or $\frac{4}{100}$ of one per cent., fluctuating more or less in accord with the changes in the proportion of oxygen. Ozone, another, not very constant nor an abundant element, is found in the atmosphere most at night and after storms with lightning. It is supposed to be composed of three measures of oxygen pressed into two. It is said to be a powerful oxidizer, corroding both organic and inorganic substances, and quick in showing its power. When inhaled in concentrated form, it is said to irritate to a high degree the mucous surfaces with which it comes in contact; and in certain catarrhal affections, when in excess in the atmosphere, may be a direct exciting cause of diseases of that character. It is

said that a full atmosphere of oxygen, charged with $\frac{1}{240}$th part of its bulk of ozone, becomes rapidly fatal to animal life, from congestion of the right side of the heart and lungs. The cardiac action becomes feeble, the respirations slower than normal, and the blood in the heart and lungs give evidence of super-carbonization having been the cause of death. Animal life and the maintenance of animal heat are so completely dependent upon taking into the circulation of the blood through the lungs a given quantity of oxygen, that the slightest diminution of the volume of air taken in, or a less proportion of oxygen, is felt almost immediately. Either deep breaths, or a rapid breathing, if the lungs have become congested, are required to make amends for the deficiency. Even a very slight change in the proportion of oxygen in the atmosphere of a room or locality is readily felt by the average individual. A sighing respiration, or involuntarily raising the arms above the head when asleep, are indications that the individual needs more oxygen than he or she is getting from the atmosphere. The burning of a candle in an atmosphere to be tested as to its safety, is considered a safe practice. Life will be maintained for a short time in an atmosphere that will not maintain a candle flame. A candle will go out in an atmosphere of $20\frac{1}{2}$ to the hundred, while life may be maintained for a few minutes in an atmosphere of $17\frac{1}{5}$. The sponge-diver by rapid, deep breathing, super-oxygenates his blood, so that at times he can remain under water, and without breathing, for three minutes, where the unpracticed individual could scarcely remain one minute at a time. In growth, development, and even in decay, oxygen is ever in demand. Its affinities are almost universal and almost unlimited; but the supply is equal to the demand. From the changing and decomposing vapors of ocean and stream; from every plant that grows; from the grass-covered hill and plain; from every leaf and stalk that develops, and from every flower that blooms, a due proportion is contributed to keep up the great supply. This all-pervading element is constantly entering into new combinations, hastening development by contributing its share, or, in the event of death, hastening change and decay. Its affinities for the flinty rock, for steel and iron, for gold, silver and platinum, and, in fact, almost everything in nature but the diamond, enables man to control and use it in manufactures and commerce, as well as in the

field of hygiene. Without oxygen the furnace that makes it possible to work and mould the material, the great ship of iron or steel would not be made to traverse the ocean swiftly and safely. Nor would the locomotive be made to run at great speed in safety upon the rail of steel, drawing after it heavy coaches filled with travelers seeking health and comfort, or perhaps intent on business.

The skin covering the body protects it from any irritating influence that would be possible from the elements entering into the composition of atmospheric air. But a burn or scald, in fact a wound of any kind opening the skin and allowing the air to come in contact with an unprotected surface, that contact inflames and makes the part sore, and causes pain, redness and swelling, compelling attention. Dressings sufficiently dense to protect the injured surface from the irritating effects of oxygen, relieve the pain, allay inflammation, and allow the part to heal. Any surface unprotected from atmospheric air, as the larynx, trachea and bronchia, when inflamed from any cause, is doubtless rendered worse and kept sore, until secretion or pus formation covers the sore surface. When atmospheric air is allowed, or cannot be prevented from entering a vomica or other pus cavity, rapid destruction of tissue is seen, doubtless from free oxidation of the already diseased surface. In an acute inflammation, the vitality of parts involved is generally sufficient to set bounds to a local inflammation, hedge it in, and notwithstanding the aggravating influence is still there and operative, heals up the diseased surface.

It is more than probable that the change for the better in many tubercular patients, after going to a high, dry atmosphere like that of Colorado, may be due to but a moderate tubercular deposit in the lungs with a rare and very light atmosphere; so light as to very materially lessen the irritating effect of oxygen upon the lung-tissue that is diseased. Where a large proportion of the lung structure is filled with tubercular deposit, and the patient passes from a dense to a rare, light atmosphere, the effort to supply the necessary life-sustaining element, and the deficiency severely felt, the heart is unbalanced in its action. In this condition the patient is constantly oppressed, and may bleed more or less freely. Patients that have extensive tubercular deposits in the lungs, or who have tubercular diarrhœa, are, as a rule, worse in a rare atmosphere. Asthmatics,

where there is no heart complications, are generally better in a rare atmosphere. And those who have palpitation or any irregularity in heart action are better at the sea-coast. Where chills and hectic fever have become a prominent feature in a tubercular case, usually a warm coast atmosphere will do all that a change of place or atmosphere can do for such cases. But, at times, patients are seen to recover perfectly who have had hectic fever and the characteristic cough and expectoration, with more or less hæmorrhage from the chest, by a residence in a warm atmosphere found above the malarial line. These have generally been subjects of malaria in the localities where the lung disease showed itself or had its first development. Patients that are not tubercular, but saturated with malarial poison, are often speedily cured by a residence in a high, rare atmosphere. Malarial germs are not seen above a certain line or altitude. And when a patient has been subject to their disease-producing influence, it disappears effectually and rapidly when above that line. The higher the more rapidly. Malarial influences are seen in and along nearly all the tide-water streams falling directly into the ocean from the Connecticut river to the Gulf of Mexico. The streams that empty into the bays are even worse than those emptying directly into the ocean.

This malarial influence extends as far up the streams as tide-water extends. And along the larger streams in the Southern States many of them are malarial more than half their length. The Mississippi and Missouri together have nearly two thousand miles in extent of malarial territory. For most of the year, except in a very few places, there is nothing in the atmosphere of these streams to indicate that there is a disease-producing power; nothing, at least, that is appreciable to the average observer.

Sea-level, upland and mountain have been considered in connection with health. And as there is an opportunity to go below the sea-level in the consideration of our subject, it would scarce be complete without going into some of the depressions in the surface of the earth, and there making some comparisons. On the Southern Pacific Railroad there is a long stretch of track that is below the common ocean-level. It would be natural to suppose that below a certain level there would be springs of water, moist or boggy lands, but in this locality morass and fen are scarce; sage, brush and chap-

arral are mainly the products of the soil. The vegetable growth is usually an index to the thrift and healthful condition of a locality. Taking into consideration the dry stunted growth, scant supply of water and sparse population, two hundred feet of a depression does not add to health, thrift or the longevity of the inhabitants. The intelligent physician would require something more than what is known of the locality to recommend it to a patient seeking health.

If we turn our attention to the opposite side of the globe, we will find a much greater depression, and one that has a more extended history. The valley of the Dead Sea is more than twelve hundred feet below the common ocean-level. History tells us that it was as thrifty as the garden of the Lord, and that populous cities occupied its plains. But it is not so now. The river Jordan, nearly two hundred miles in length, pours its limpid waters continually into this basin of salt. But little animal life or activity is seen about this valley below the entrance of the Jordan. The evidences of life and activity become less as you approach it. The feathered tribe avoid it, and the wild goats of Engedi look down upon its dark waters, but shun its banks, preferring the thin pickings about their mountain homes far above.

The Jordan springs, at once a river, from the foot of Mount Lebanon, three hundred feet above the level of the Mediterranean Sea. And as its pure waters, made by the melting snows of old Lebanon, ten thousand feet above the ocean, flow down the valley, they carry with them gladness and health until that influence is lost in the dark basin below.

After looking at atmospheric influences at the sea-level, on upland plain, on the mountain, and in the low plains of earth, we can but conclude that there is no air so pure and healthful as that inhaled in Eden's Bower before the embarrassments of transgression prepared a foundation for pathological changes in the condition of the race.

DISCUSSION.

Dr. Bushrod W. James, in discussing Dr. Cooper's paper on "The Air We Breathe," agreed with him in the views he had advanced, but there were other points in connection with the atmosphere of a general character which involved the longevity of healthy

individuals, as well as the prolongation of the lives of invalids, and the assistance which atmosphere renders as an aid to the recovery of the latter which should have been mentioned. The impurities of atmospheres, which cause maladies and increase the symptoms of existing diseases when they have made an inroad upon the human system, should also claim our attention and study. We all know how important it is for a person living in a malarious region, or any injurious atmosphere, to be removed to a different or a purer one in order to effect recovery.

This is not only the case with regard to malarial localities, but even the native climate, or the one in which invalids are in the habit of living, affects them at times injuriously, and a change of location or climate is essential to such cases. For instance, frequently persons living in a seashore climate have to remove to a rolling or mountainous country in order to insure recovery, and *vice versa.*

So, likewise, consumptives, asthmatics or persons afflicted with heart diseases, frequently have to change their place of residence in order to afford them the most comfortable and congenial air to breathe, and to place themselves in surroundings proper for recovery.

This country affords a greater variety of climates than any other government in the world, because of its extent of territory, covering, as it does, lofty mountain peaks, protected valleys, open plains, hot prairies (and temperature variation between) and plateaus, Alaskan coldness and desert heat, with many intermediate temperatures, together with the most balmy and invigorating climates anywhere to be found, such as exist in many parts of the Rocky Mountain region, Texas, California and elsewhere. Hence, the health resorts of the country embrace mountain, lake, seashore, winter and summer climates, to be picked out at any season of the year, it being simply a matter of travel and expense to reach any or all of these points at the proper season for such resort-residence, to escape the severities of any special place or climate.

The climate, or the kind of air to breathe, should be a matter of as careful study and selection as the proper Homœopathic remedy is in any special case of disease. A Florida, or a Colorado, or a Minnesota, or a California, or a Texan climate might each be wrongly selected if they are not all well understood, as well as the adapta-

bility of each individual case to one or the other of these climates. Then, again, special localities in these climates are to be also carefully selected as to altitude, moisture, exposure to high chilling winds or parching heats, or as to comfort of hotel or boarding accommodations and agreeable associates.

An excellent location in the mountains, for instance, might only have a rude mining camp or village for accommodations to be selected from, but wealthy invalids would not be well cared for, or even secure in person or property, were it known that they were tourists, and there simply to recuperate and to spend money, and not to become interested in mining.

During the past three months I have had an opportunity of studying the high altitude of the Rocky Mountains by personal observation and residence, most of the time being located from seven thousand to eight thousand feet above the sea-level in the heart of the mountains along the continental divide. Asthmatic cases coming to that locality were almost invariably relieved of their dyspnœa and stridulus breathing. Persons afflicted with other bronchial diseases, and even consumptives, were usually relieved of their oppression, and were more comfortable, provided they did not use any amount of exertion; but when they did exert themselves, considerable difficulty of respiration occurred from the rare state of the atmosphere.

Heart diseases were made invariably worse, and persons of a highly nervous temperament, and afflicted with nervous diseases, while they were able to overcome insomnia present in a lower altitude, could rest quite well throughout the night, and yet any long-continued presence of such individuals in those regions usually produced an increase of the nervous symptoms. Females from low altitudes were unusually prone to nervous feelings.

A great amount of exposure can be endured both to sudden storms that arise there, as local thunder-showers, which arise almost daily, and are very severe, with violent electrical displays all the summer months. The high, cool winds which are met with on the mountain tops whenever you reach an altitude of fourteen thousand feet or more, such as is found upon the top of Pike's Peak, James's Peak, Gray's Peak or Long's Peak, are well borne by healthy travellers, provided no perspiration is present.

The seven thousand feet elevation is not only dangerous to cases of heart disease, but the more lofty regions are positively hazardous to persons afflicted with cardiac diseases (even for an hour or two), and healthy persons are affected with symptoms which are extremely annoying, and probably not altogether free from danger, such as vertigo, great oppression, with gasping respiration and strong efforts to catch the breath on the least exertion. These symptoms become so intense that frequently you have to thoroughly recline in a recumbent posture for some minutes until you are able to again respire with ease, and until the intense vertigo, with blinding sensations, and the great effort to breathe, and the palpitation of the heart, and possibly the epistaxis, passes over.

I was convinced that the extremely high altitudes were dangerous to many classes of cases, and should not be recommended, even if the patient can reach the summit by the easy route of the Cog-wheel Railroad, now placed from the valley of Ute Pass to the top of Pike's Peak mountain.

The valleys and gorges that are shut in, however, by the high peaks or mountain cliffs, are sometimes delightful during both the summer and winter months, and quite a goodly number of the places can be visited by invalids during the winter and in summer by tourists, such as Georgetown, Central City, Idaho Springs, Ouray, Salida, or even Leadville, Glenwood Springs and Aspen, etc., which are somewhat higher localities than the others named.

Some of these balmy climates, with pure atmospheres, have additional inducements in the way of warm baths of either pure hot water or of minerals, such as soda, sulphur or other minerals mingled with them, which are used either for drinking or bathing purposes; but there is no doubt that the purity and rarity of the atmosphere exerts the largest amount of influence in these high Colorado climates.

Mountain fever, a mild form of typhoid variety, is very prevalent, however, in summer, and so is pneumonia and diarrhœa. Many miners come out of the mines in a perspiration, stand in the cool winds, take a severe cold, which may terminate in a pneumonia.

THE HYGIENE OF THE ALIMENTARY CANAL.

BY M. S. WILLIAMSON, M.D., PHILADELPHIA.

THE preservation of health and prevention of disease are the most important missions of the physician, and when, in this connection, we study the alimentary canal, there is no need of an excuse for occupying some of your time.

While in health, an excellent way to prepare the stomach for the morning meal is to take a drink of cold water (but for those who are suffering from catarrhal dyspepsia, hot water is better) to wash away the accumulated mucus, and thus to enable the gastric juice to act upon the food. In cases where there is loss of power of the stomach to act, especially where there is irritability, the action of hot water after eating is very soothing and of marked benefit.

The correct stand to take with reference to forbidding certain articles of diet is not so much that they will interfere with the action of medicine, but that they will disagree with the patient by causing indigestion, or will make the symptoms present more severe.

It is not possible to lay down any general rules for the diet, but each patient should be examined with regard to what kind of food should be eaten. The old-fashioned diet lists have often made us appear ridiculous in the eyes of intelligent people.

From the earliest period of life to the decrepitude of advanced years, the amount taken, the quality and time for meals, should be made suitable for each person.

To start at the earliest stage of existence, the mother's diet has a direct influence upon the unborn child, and to a great extent we may control the development of the bones and size of the child. But this may be carried too far and cause starvation.

The mistaken notion of many mothers in thinking that their milk is the best kind of food, must often be combated, as in England it has been found that about ten percentum of infants do not thrive on their mother's milk, and it is the duty of the family physician to recognize this at an early date, and to advise feeding the child on something else before serious mischief has been done; and possibly,

by treating the mother, building her up, and by paying attention to what she eats and drinks, after a time the child may return to what should be the natural diet.

In the absence of mother's milk, or in a case where this does not agree with the child, we must give cow's milk if that can be digested, or, where a good article cannot be procured, condensed milk, and there are many preparations of baby foods which may be tried. In some cases, where the mother has not enough milk to satisfy the child, we are right in urging the mother to retain her milk and use the bottle for the additional meal, the notion that mixing milks is injurious having been found to be erroneous. It is often very difficult to keep milk from becoming sour in hot weather. The use of the condensed milk is often of advantage, especially at night.

As the child grows it is necessary to add to the diet, and when the time comes that eight ounces does not satisfy the appetite, its strength should be increased, so that after a hearty child is nine months old they will require the milk to be given undiluted.

After the child is a year old, we may add to the diet list some of the carbo-hydrates in the shape of bread with the milk, or crackers and milk, but I have found the best preparation to be oat-meal with the milk. We must remember that children do not demand the great variety of food that older persons do, that they will continue for months and even years to eat with great relish a large plate full of oat meal porridge at breakfast time. Boiled eggs and soups may be given at dinner, but light suppers are very important for the early years, and many children who have night coughs and bad dreams can have these troubles removed by those having care of them giving only light food at supper time.

Not only in early life, but those of a larger growth, will feel much better in the morning and eat their breakfast with more relish if they eat only food that is easily digested at supper time, and make it a rule of life never to eat anything after supper.

It is important not to sow the seeds of future trouble by allowing the use of condiments or of highly-seasoned food.

During middle life, when the stage of growth has been passed, it is astonishing how tolerant the system is, and how often a healthy person may be indiscreet in both the kind and amount of food and drink that may be indulged in; but the time comes when there will

be punishment for slight transgressions, and a headache may be succeeded by vertigo, and a little water-brash by a spell of indigestion, until there may be a chronic state of dyspepsia, and the doctor is called upon to relieve in a few hours the result of years of abuse of delicate organs, and in some cases the liver and kidneys are seriously involved before the patient realizes that there is any trouble.

With advancing years we often have a more ambitious appetite than there are powers to digest and assimilate food, and the physician has one of the most difficult problems to solve; it is not what he thinks is best for them to eat, but what he can get them to eat; and when the natural tonics of fresh air and out door exercise cannot be taken, the use of malt in some form may stimulate the appetite. Meat is what is needed, and stewed meats thickened with potatoes, barley, rice or split peas form a good food for the mid-day meal. Extract of meat and milk punch in very old persons may be given with advantage when they are not able to eat ordinary table food.

Regular habits of living apply very strongly in reference to all parts of the body, and especially to the alimentary canal. We must remember that there is a time to work and a time for rest, and the usual treatment when there is a constipated condition of the bowels of using powerful means to force is very much like applying the whip and spur to a tired horse: he will go faster for a time, but the time comes when even those incentives will not be followed by any result, and a break-down will follow.

The involuntary muscles which surround the alimentary canal are like the other forms of muscular fibre, and require exercise to keep them in a healthy condition; and the habit of going after the morning meal is one that is very important, and from early childhood should be encouraged; and where the aid of the voluntary muscles are not sufficient to accomplish the object, then the use of glycerine injections or gluten, or glycerine suppositories, are not only more certain but have not the bad results that spring waters and cathartics usually cause in the way of irritating the canal for a long distance, as frequently the trouble has been that they have not made efforts in the proper direction, or the trouble is caused by a mechanical condition of the fæces at the outlet, and when that is removed there is no further trouble.

DISCUSSION.

Dr. Smedley said that, in his opinion, milk is *the* article of diet for children, and advocated the sterilizing of all milk, and this should be done at the dairy.

Dr. B. W. James said that all milk becomes changed somewhat in transit unless it is carried in cans filled full and hermetically sealed. The best substitute is condensed milk which is not too sweet. A point he made was that the mother should not feed the child too often. If she does, the quality of her milk is likely to deteriorate. She should have regular prescribed hours for feeding.

Dr. Seip thought another point to be considered was the length of time necessary to satisfy a child. The child may not get enough, or may get too much. He always cautioned a mother about taking the cream off the top. He suggested to her that she shake the milk before pouring out any of it.

Dr. Bowie suggested zweibach for children after the milk period.

Dr. Williamson gave it as his experience that, practically, sterilized milk is a disappointment. Its taste is disagreeable, and patients won't take it. Where at all possible, he sends his patients to the country.

Dr. Eliza Lang McLure advocated the use of fresh condensed milk, which should not be diluted too much.

FALLACIOUS HOUSE-DRAINAGE.

BY JOHN C. MORGAN, M.D., PHILADELPHIA.

Modern appliances in all departments of life are often so attended by drawbacks that reactionary conservatism receives unlooked-for support. The revelations of experience in "sanitary" house-drainage emphasize this remark. A recent essay,* to which I here ac-

* *The Sewer-Gas Question*, by E. D. McClellan, M.D.

knowledge my indebtedness, calls attention to so many of these drawbacks that one is tempted to ask if we have, indeed, substantially advanced at all. We may hope, however, that new light may be had through the instruction derived from these discouragements.

It is needless, of course, to detail the basic matters of trap-sealing, nor of separate but communicating pipes for ventilation of drains, nor yet the common facts of faulty plumbing, syphonage of water-traps, etc., but we may well consider some of the less-known causes of these events with the fallacies attending careful work and the access of poison to our houses, particularly as the best approved plumbing furnishes a long list.

First.—The water-seal in the usual S-trap may be displaced toward the house during the rush of fluids from a higher point at the same time when the drain below the trap may happen to be at all clogged, this arising from the temporary compression of the air in the pipes between the upper flow and the lower obstruction.

Second.—In the absence of such obstruction below the contrary movement of the water-seal, viz., syphonage, downward, takes place on this same flushing from above, acting to form *a vacuum* below the *seal* and emptying it downward following the flush. The efficient cause of this is simply the *atmospheric pressure* in the room containing the fixture. The opening of the vent-pipe above the roof goes far to diminish this vacuum and equalize the atmospheric pressure on both sides of the water-seal; nevertheless, a strong rush of water from above sometimes overpowers this, unseals the trap, and thus admits sewer-gas through it. If, in any way, the ventilating opening above the roof be impaired, the liability is, as manifold experience shows, much increased. Some illustrations of this complication will be given directly. If there be no upper opening at all, the case is at its worst.

Third.—Traps and valves, originally well constructed, may suffer impairment. Balls, as of india-rubber, used as valves for instance, may gradually undergo flattening or elongation; thus they cease to fit the opening against which they impinge, and so fail to close it; or, again, they may become foul and stick fast. In either case the result will be a "fallacious drainage."

Fourth.—A form of trap wholly enclosed in a metallic case, and hence called a "bottle-trap," may undergo corrosion of the pipe, or

there may be defects or splits, called "blow-holes," therein, as originally manufactured. The containing metallic "bottle" conceals all such defects, but conveys sewer-gas to the house as fast as transmitted by these concealed openings.

Fifth.—The use of pipes with soft-solder joints may, in like manner, allow of the escape of sewer-gas when these joints become impaired, as they sometimes do.

Sixth.—The upper bend of a water-syphon trap is liable to more or less clogging by accumulation of textile débris-threads, shreds of cloth, etc. These extend toward the drain if retained, and thus is established a capillary absorption and gradual discharge of the water-seal. This is mostly hidden, especially if the fixture be rarely used, and seldom flushed and supplied with fresh water. *Local retention of débris and local fouling*, in any case, are *constant* results of *deficient flushing* of traps with fresh water over and above other accidents.

Seventh.—Ventilation-pipes (or "vent-pipes") to the roof, so justly valued as a preventive of sewer-gas retention, may prove but fallacious when of too narrow a calibre. Similar deficiency occurs when the normal upward air-current is otherwise impeded, as *branching* toward numerous separate fixtures, and even an *angular course* of the pipes. These should be as simple in form and as straight in direction as may be. It will be remembered that the upward ventilating air-current, with local as well as deeper gaseous emanations, may be detained whenever the downward water flushing, along with the effete fluids, occurs. Branching and angularity of these pipes are usual faults in so-called "reconstruction plumbing" in old houses. Furthermore, when the upward current is very strong, say five to eight feet per second, as often happens, this itself may produce, on the other hand, a practical vacuum in the pipes, which tends to syphonage of the traps, and this is determined as before by the unequal and excessive atmospheric pressure within the house. Still further, the drain or "waste-pipe," separate as it is from the "vent-pipe," may, at the same time, happen to be obstructed, and thus the vent-pipe will attract the drainage, when the forcible upward ventilation will cease, and the downward drainage current in the vent-pipe may now discharge the water-seals by syphonage. Such is

sometimes the origin of faulty and fallacious, as well as dangerous, drainage in actual practice.

Eighth.—*During severe storms*, a great flow of storm-water in the lower drains tends to form a downward current in the vent-pipe, and, at the same time, the passage of the gale above the pipe tends to attract the same air-column from the pipe upward, exhausting it, producing the practical vacuum, and unsealing the traps.

Ninth.—Another drawback to the usefulness of the vent-pipe is that it greatly favors the *evaporation of the water* by which the traps are sealed. When, in the absence of a vent, the traps are flushed with fresh water but rarely, or not at all, as when a family is absent from home on a summer vacation during dry, hot weather, this evaporation is completed in about *two months*, but, with the assistance of a ventilation pipe, two weeks are sufficient to dry up the seals. If the traps be shallow, the process is still further shortened. Such an unoccupied house, on the return of the family, may prove to be a very typhoid factory, every curtain and quilt and carpet being covered with germs in the form of *dust*. A habitual disuse of the traps in contiguity with the "spare room" may at any time prepare the same state of things for the coming guest. Dr. John S. Billings, United States Army, sounds an impressive warning as to this danger, coming by evaporation of the water-seal of the drain-trap.

Tenth.—The ventilation pipe, when of iron, is naturally subject to *oxidation*, more or less rapid. The gradual accumulation of rust within its cavity closes the vent—it may be, entirely, as if it had never been—and thus the gaseous poisoning of the house becomes probable. If the pipe be too small, or if angular, or branched, this bad effect of rust is hastened, of course. Non-oxidizable pipes are to be preferred, of course.

Eleventh.—Like obstruction may and does occur during the winter through accumulation of snow and ice about the top of the vent-pipe, and again, practically, there is no ventilation of the drainage, and house-poisoning becomes probable. No doubt this cause has often defeated careful and scientific plumbing work, at times when epidemic influence alone seemed accountable for prevalent disease. In all such obstructions, the downfall of drainage produces, besides the *stasis* mentioned, a sufficient vacuum to syphon and discharge

the water-seals of the traps, and thus admit the sewer-gas to the house.

Twelfth.—Various "automatic" methods of regulating the action of the traps depend upon accurate metallic joints and contacts, or else upon metallic edges shutting into water grooves, whereby the gases are supposed to be excluded. These, however, are very prone to fail, because the metal fittings become impaired, and the joints cease to be accurate; or the water may evaporate, and so unseal the valve. When, in a flushing-tank, even, a float is used to automatically work a lever and metallic joint, a little fouling or rust of the hinge or of the joint itself may render it useless. The water-seal fails in consequence, and sewer gas may freely pass.

Addenda.—These numerous ways of failure of careful and expensive plumbing would seem to be enough to mention; but there are some cognate matters which should be added here in relation to fallacious house-drainage. These partly concern the *local* origin of foul air at the various fixtures within the house.

For instance, we note "*compound*" *discharge-pipes*, *i.e.*, those where one or more such pipes empty into a trap belonging to another; this renders all the pipes "air-bound" or "stuffed." Whenever this internal pressure is increased, the gases are forced through the water-seal into one or more of the pipes opening into the house; or, the seal itself may be forced out. This "double trapping" is a common fault in old plumbing.

In water-closet fixtures, with a *drop-pan* and the double trapping, *foul matters often accumulate below*, owing to vacuum in the other pipes joining the main pipe, this vacuum being itself due to the downward movement from this main pipe. The said vacuum in the smaller pipes, once formed, of course resists its further emptying. It is thence impossible to perfectly clear it, when the pan is dropped with the usual meagre flushing and the usual lack of a vent-pipe.

Again, long, narrow, angular or compound branched *ventilation pipes* may themselves become *clogged* by such accumulations, drained from the several outlets, and the upward current of ventilation must thereupon cease. They thus become mere reservoirs of foul air, communicating constantly with that of the house.

In some instances the very *smallness* of the *water-closet bowl* is itself a sufficient cause of local fouling, in two ways, viz., by the

easy adherence of filth, and by the rapid evaporation of the seal-water.

Rubber ball valves, as already stated, effect local fouling if they become soft by soaking. When in this condition they are so compressible that they may be forced through the opening which they should close, and into the drain passages beyond, clogging them, with the aid of other matters; and they may also, failing to act as valves, admit sewer-gas.

A stingy use of water in flushing the traps, as is evident, will be a constant cause of local fouling.

Noisy flushing fixtures are a hindrance to the free use of the water, and are thus an indirect cause of local fouling, trivial but important.

Non-access of fresh air and sunlight, nature's great disinfectants, will, as everybody knows, encourage the local accumulation of foul odors, and necessarily of noxious germs.

Even *wooden closet finishings* are known to favor a similar state of things.

Besides all the foregoing causes of local and imported foulness, there are some others depending on *erroneous theories of sanitary plumbing*. This is the point of a controversy between the Philadelphia Board of Health and a noted plumbing firm, H. W. Brock & Co. The Board, by its inspectors, upholds the trapping of every main house-drain, near its sewer connection; this the firm resists, on the ground that it is useless, at least since the flow of storm-water in the culvert tends always to syphon and unseal this main trap, whilst high-tide water, twice daily, closing outlets, tends to favor the ascent of sewer gas under overwhelming pressure into the house. This, as to the drain-pipe, alone. At the same time, of course, the upward current of the ventilation-pipes, and the draught from and purification of drainage, up to the roof is more free, yet gradually without this main trap; and they have further perfected this movement by introducing within the vent-pipe a small gas-jet, made visible by a glass door opening into and controlled within the apartment. The well-known aid of hot air in upward ventilation is thus effectively invoked.

Dr. McClellan's remedy for the imperfect operation of the water-seals consists in discarding it altogether and adopting the mercury

cup in its place. Indeed, the commercial interest of a patent of this kind seems to have been the principal motive of his essay. There can be little doubt of the real advantage of this method of sealing.

Lastly.—No physician or other influential citizen should fail to use every effort to secure the building of culverts of proper form. This is clearly *the oval,* the small end of the egg outline being downward. This, in dry weather, is easily kept free by even the small bulk of passing fluids; whilst, in case of heavy rains, the larger diameter above fully accommodates the storm-water.

GENERAL BUSINESS.

THE Committee on President's Address made their report as follows, viz.:

REPORT ON PRESIDENT'S ADDRESS.

TO THE HOMŒOPATHIC MEDICAL SOCIETY OF PENNSYLVANIA.

Mr. President: The Committee to whom was referred the Address of President Dr. Bingaman would respectfully report:

1. As to the suggestion of making those who have been members of the Society for twenty-five years seniors, without dues, and constituting them an advisory board, we would recommend that until the Society shall become self-sustaining no such action ought to take place; that if such a class were needed, thirty years should be the minimum term of membership, and no special function should attach to them as seniors.

2. We would commend the recommendation of leaving the subject of Medical Education and Medical Examiners' bill to the action of the Society, after it shall hear a report from the Special Committee upon those topics.

3. *Insane Asylum.*—We recommend that the Committee on Legislation be especially instructed to use every proper means to have the State set aside the next institution of this kind for the use of patients to be treated by the Homœopathic method.

4. That in addition to the regular Legislative Committee, one member from each county (when possible) be appointed to advise and assist the said Committee in the prosecution of its work.

5. The subject of a depleted treasury having already been acted upon, needs no further recommendation.

Respectfully submitted,

E. C. PARSONS,
JOHN E. JAMES,
Committee.

REPORT ON STATISTICAL BLANKS.

The various blanks for statistical reports, which were referred to us, your Committee would recommend the adoption of those in use by the American Institute of Homœopathy, or such modification as may be needed for State Society purposes, so that greater accuracy may be secured in all statistical affairs pertaining to our school and its work.

Respectfully submitted,
E. C. Parsons,
John E. James,
Committee.

There being no further business before the Society, the election of officers for the ensuing year occurred, with the following as a result of the ballot:

President.—Aug. Korndœrfer, M.D., Philadelphia.

First Vice-President.—E. C. Parsons, M.D., Meadville.

Second Vice-President.—M. J. Chapman, M.D., Pittsburgh.

Treasurer.—J. F. Cooper, M.D., Allegheny.

Corresponding Secretary.—E. R. Snader, M.D., Philadelphia.

Recording Secretary.—J. Richey Horner, M.D., Allegheny.

Necrologist.—W. J. Martin, M.D., Pittsburgh.

Censors.—Sarah J. Coe, M.D., Wilkesbarre; Joseph E. Jones, M.D., West Chester; Clarence Bartlett, M.D., Philadelphia.

The following Bureaus and Committees were then announced:

Materia Medica and Provings.—Dr. M. S. Williamson, Chairman; Associates, Drs. Chas. Mohr, Z. T. Miller, J. C. Guernsey, C. S. Middleton; Collaborators, Drs. Aug. Korndœrfer, L. W. Thompson, A. Norris, J. S. Boyd, R. K. Fleming, H. W. Fulton, S. W. S. Dinsmore, R. Y. Ramage, W. H. H. Neville, S. F. Shannon.

Ophthalmology, Otology and Laryngology.—Dr. C. M. Thomas, Chairman; Associates, Drs. W. H. Winslow, H. F. Ivins, W. H. Bigler, H. K. Hoy, R. W. McClelland, W. W. Speakman, I. G. Shallcross, F. P. Wilcox.

Pathology and Pathological Anatomy.—Dr. W. C. Goodno, Chairman; Associates, Drs. A. R. Thomas, C. V. Vischer, Thos.

Dunning, C. C. Rinehart, W. K. Ingersoll, F. W. Messervè, T. Pratt.

Clinical Medicine.—Dr. Joseph E. Jones, Chairman; Associates, Drs. Clarence Bartlett, H. M. Bunting, H. Pitcairn, Samuel Starr, M. M. Walker, E. C. Parsons, E. R. Snader, W. W. Van Baun, R. P. Mercer, G. Maxwell Christine, W. H. Keim.

Pædology.—Dr. W. J. Martin, Chairman; Associates, Drs. Wm. Cowley, D. R. Harris, W. G. Dietz, John Cooper, C. A. Yocum, W. D. King, G. M. Getze, F. W. Boyer, E. E. Briggs, J. H. Closson, Thos. Reading, J. W. Allen, J. B. Sullivan, A. P. Bowie, Chas. Gangloff.

Surgery.—Dr. J. W. Giles, Chairman; Associates, Drs. L. H. Willard, C. P. Seip, John J. Detwiller, J. H. McClelland, J. H. Thompson, John E. James, T. J. Gramm, W. B. Van Lennep, C. A. Wilson, Malcolm Macfarlan.

Sanitary Science.—Dr. J. C. Burgher, Chairman; Associates, Drs. J. F. Cooper, B. W. James, Pemberton Dudley, J. C. Morgan, J. S. Crawford, F. R. Schmucker, Daniel Karsner, C. W. Perkins, C. Van Artsdalen.

Obstetrics.—Dr. J. L. Ferson, Chairman; Associates, Drs. J. N. Mitchell, J. R. Horner, Edwin Van Deusen, W. F. Edmundson, I. G. Smedley, Jos. M. Gerhart, Theo. Johnson, O. B. Gause, J. A. Ballard, H. C. Chisolm.

Gynæcology. —Dr. Millie J. Chapman, Chairman; Associates, Drs. C. H. Hofmann, H. J. Sartain, S. J. Coe, M. J. Branson, B. F. Betts, Chandler Weaver, R. C. Allen, W. H. Jackson, P. A. Bier, J. S. Rankin, Elizabeth Uncapha, C. H. Lee.

Organization, Registration and Statistics.—Dr. E. R. Snader, Chairman; Drs. Clarence Bartlett, J. R. Horner.

Delegate to the Southern Homœopathic Medical Association.—Dr. Millie J. Chapman.

Pittsburgh was selected as the place for meeting in 1891.

MEMBERS PRESENT.

Clarence Bartlett,
B. F. Betts,
W. H. Bigler,
C. F. Bingaman,
A. P. Bowie,
J. S. Boyd,
Mary Branson,
T. M. Bulick,
H. M. Bunting,
T. H. Carmichael,
M. J. Chapman,
G. M. Christine,
J. H. Closson,
S. S. Coe,
J. F. Cooper,
E. E. Davis,
W. G. Dietz,
S. W. S. Dinsmore,
Pemberton Dudley,
J. M. Gerhart,
J. W. Giles,
W. C. Goodno,
E. M. Gramm,
G. E. Gramm,
T. J. Gramm,
J. J. Griffith,
Silas Griffith,
W. M. Griffith,
B. B. Gumpert,
O. S. Haines,
W. A. Haman,
Joseph Hancock,
J. E. Harner,
D. R. Harris,
W. A. Hassler,
J. Richey Horner,
H. K. Hoy,
H. F. Ivins,
B. W. James,
J. E. James,
T. N. Johnson,
Joseph E. Jones,
Daniel Karsner,
William H. Keim,
Aug. Korndœrfer,
William H. Malin,
W. F. Marks,
D. R. Marsden,
A. M. Marshall,
W. J. Martin,
E. W. Mercer,
F. E. Merriam,
F. W. Messerve,
C. S. Middleton,
J. N. Mitchell,
C. Mohr,
W. P. Mullin,
Robert Murdock,
Eliza Lang McClure,
W. H. H. Neville,
E. L. Oatley,
G. W. Parker,
T. E. Parker,
E. C. Parsons,
Eliza F. Pettingill,
Hugh Pitcairn,
W. C. Powell,
Trimble Pratt,
C. G. Raue,
L. W. Reading,
Thomas Reading,
Emma T. Schreiner,
C. S. Schwenk,
W. A. Seibert,
C. P. Seip,
J. F. Slough,
I. G. Smedley,
E. R. Snader,
W. W. Speakman,
Van R. Tindall,
W. H. Tomlinson,
D. B. Umstead,
C. Van Artsdalen,
W. W. Van Baun,
Edwin Van Deusen,
W. B. Van Lennep,
Carl V. Vischer,
M. M. Walker,
Chandler Weaver,
W. P. Weaver,
M. S. Williamson,
C. A. Yocum.

VISITORS PRESENT.

J. B. Kniffin,
Harry Litchfield,
P. H. Ealer,
H. I. Jessup,
C. H. Hubbard,
S. C. Webster,
Isaac Van Deusen,
Lemuel Stephens,
Isaac Cooper,
Walter Strong,
Emma Clarke,
J. D. Boileau,
R. E. Tomlin,
John Arschagouni,
A. A. Jones,
William Spencer,
E. E. Snyder,
I. D. Johnson,
F. E. Williams,
M. A. Custis,
W. E. Meehan,
Hattie Van Buren,
Mary Cooke,
Mrs. W. H. H. Neville,
Mrs. M. M. Walker,
Mrs. J. Hancock,
N. W. Fryer,
George D. Woodward,
Mr. James F. McClure,
Charles W. Karsner,
M. D. Youngman,
Mrs. Clarence Bartlett,
O. H. Paxson,
Mrs. C. S. Middleton,
Miss Goodno,
M. F. Middleton,
Mrs. M. F. Middleton,
Mr. D. G. Dyke,
Mrs. William M. Griffith,
L. L. Lazear,
Mrs. Longstreth,
T. Hart Smith,
Mrs. J. F. Cooper,
Miss Ella Goff,
Mrs. Dr. J. R. Horner,
A. D. Baldwin,
P. H. Dudley,
J. R. Osman,
L. T. Ashcraft,
A. A. Norris,
W. S. Morris,
Mrs. F. E. Williams,
Mrs. W. G. Dietz,
Mrs. C. H. Hubbard,
A. W. Bayly,
Mrs. Dr. A. W. Bayly,
A. E. Dumont,
George W. Crosby,
Miss E. De Mott.

On motion, a vote of thanks was tendered the presiding officer of the Society, the authorities of the college for the use of their building, the hospital officers for courtesies extended, and to the press of Philadelphia for the uniformly good reports of the meetings.

On motion, the Society adjourned.

Respectfully submitted,

J. Richey Horner,
Recording Secretary.

CONSTITUTION AND BY-LAWS.

CONSTITUTION.

ARTICLE I.—Name and Object.

This Association shall be known as the Homœopathic Medical Society of the State of Pennsylvania.

Its object is the advancement of medical science.

ARTICLE II.—Members.

This Society shall be composed of active, honorary and corresponding members, who shall be chosen in conformity with the By-Laws.

ARTICLE III.—Officers.

The officers of this Society shall be a President, two Vice-Presidents, a Recording Secretary, a Corresponding Secretary, a Treasurer, a Necrologist and a Board of Censors, consisting of three members, who shall be chosen at such time, in such manner and for such a period, and shall perform such duties as the By-Laws may direct.

ARTICLE IV.—Amendment.

The Constitution may be altered or amended by a vote of two-thirds of the members present at the annual meeting; *provided*, that notice of such intended alteration or amendment shall have been given to the Society, in writing, at the annual meeting next preceding.

BY-LAWS.

ARTICLE I.—Meetings.

Section 1. The annual meeting of this Society shall be held at ten A.M., at the time and place decided upon at the annual session next preceding.

Seven members shall constitute a quorum for the transaction of business.

Sec. 2. The elected officers of the Society shall have power to direct such other meetings to be held as they may judge advisable.

Sec. 3. Should any occasion arise making it advisable or necessary to change the time and place of meeting agreed upon at the previous annual meeting, the same may be done by a vote of two-thirds of the officers of the Society, with the concurrence of the Committee of Arrangements.

ARTICLE II.—Officers.

The officers shall be elected by ballot at each annual meeting of the Society, and shall enter upon their respective duties on the first day of January next succeeding their election.

ARTICLE III.—Duties of Officers.

Section 1. The President shall preside at the meetings of the Society, preserve order therein, put questions, announce decisions, and appoint committees not otherwise ordered. He shall deliver an address at the opening of the session.

Sec. 2. The Vice-Presidents, in the order of their election, shall perform the duties of the President in his absence.

Sec. 3. The Recording Secretary shall keep a record of all the proceedings and resolutions, and of all discussions that may occur in the Society; authenticate, by his signature, all papers and acts of the Society, when the occasion requires it, and bring before the Society any business needing its action not otherwise presented.

Sec. 4. The Corresponding Secretary shall receive and preserve all letters addressed directly to the Society; open and maintain

such correspondence as shall tend to advance its interests; give at least two weeks' notice to the members of all meetings of the Society; keep a record of all members, with the date of admission of each; present all communications to the Society; notify all committees of their appointment and of the business referred to them, and notify all members of their election. He shall be *ex-officio* Chairman of the Bureau of Organization, Registration and Statistics.

SEC. 5. The Treasurer shall notify, annually, all members of arrearages, collect all money belonging to the Society, and make all disbursements ordered by the Society. He shall furnish, at each annual meeting, a written report of his receipts and expenditures, and a statement of the condition of the finances.

SEC. 6. The Necrologist shall, upon the death of a member of the Society, prepare a suitable obituary and present it to the Society; he shall also forward a copy, properly engrossed, to the family of the deceased member, if so ordered by the Society.

The report of the Necrologist shall be presented in connection with the report and papers of the Bureau of Organization, Registration and Statistics.

SEC. 7. The Censors shall receive and examine the credentials of candidates for membership, and shall report to the Society, for election, such as may be found to be properly qualified.

Their report can be made in its regular order, or at the close of the report of any bureau.

ARTICLE IV.—MEMBERSHIP.

SECTION 1. *Active.*—A candidate for active membership may present to the Board of Censors a written application, signed by himself, accompanied by a certificate from two members of the Society in good standing, that the applicant has received the degree of Doctor of Medicine from an incorporated medical college, that he subscribes to the doctrines of *Similia Similibus Curantur*, and that he sustains a good moral character. If found qualified, he may be elected a member. He shall not, however, be considered a member until he has paid an initiation fee of five dollars (which in-

cludes the first year's dues), and signed the Constitution, either in person or by proxy.

Any active member removing from the State wishing to retain his membership shall notify the Society to that effect; otherwise his name shall be dropped from the roll.

Any active member who fails either to attend the annual meeting or to send a paper once in five years, or to pay his dues, shall, upon vote of the Society, be dropped from membership.

Any member who shall be unable to comply with the requirements of this Society may be continued as an active member, without payment of dues, by vote of the Society.

SEC. 2. *Honorary.*—Any Homœopathic physician, not a resident of Pennsylvania, who, from his superior attainments, may be judged worthy, may be elected an honorary member at any annual meeting, but no more than two shall be elected in one year.

Such honorary members shall have all the privileges of members, except the right to vote and to hold office.

SEC. 3. *Corresponding.*—Any Homœopathic physician residing outside of the United States may be elected a corresponding member at any annual meeting, but not more than two shall be elected in one year.

Such corresponding members shall have all the privileges of members, except the right to vote and hold office.

ARTICLE V.—DUES.

Active members shall pay annually, in advance, the sum of three dollars towards defraying the expenses of the Society.

The published proceedings of the Society will be furnished only to those members who are not in arrears.

ARTICLE VI.—BUREAUS AND COMMITTEES.

SECTION 1. The following Bureaus shall be appointed as hereinafter provided:

One of Materia Medica and Provings.

One of Homœopathic Institutes and Clinical Medicine.

One of Surgery.
One of Obstetrics.
One of Gynæcology.
One of Pathology and Pathological Anatomy.
One of Ophthalmology, Otology and Laryngology.
One of Pædology.
One of Sanitary Science.
One of Organization, Registration and Statistics.

SEC. 2. Each bureau shall be composed of not less than five members.

SEC. 3. Each bureau shall present, in its annual report, a *résumé* of the discoveries and progress in its special department, together with the papers presented for discussion. The bureaus shall report in order of rotation each succeeding year.

SEC. 4. The Bureau of Organization, Registration and Statistics shall receive all credentials of delegates to the Society; receive and preserve all reports from local or State societies, colleges and other institutions; keep a record of the number of members admitted and withdrawn from the Society; solicit an exchange of publications with other State societies, and perform such other duties as may be directed by the Society. From these data the annual report of the bureau shall be prepared.

SEC. 5. Immediately upon the close of the report of a bureau, the President shall appoint a chairman for the ensuing year; and the chairman so appointed shall, in conjunction with the President, select his associates, and the list of members of the bureau shall be announced before the close of the session.

SEC. 6. If any member of a bureau shall resign or decline to serve, the chairman of the bureau shall fill the vacancy by appointment, and notify the Corresponding Secretary of the fact.

SEC. 7. The following Standing Committees shall be appointed, as hereinafter provided for:

A Legislative Committee.
A Publishing Committee.

SEC. 8. Each of these committees shall consist of at least three members, to be appointed by the President.

SEC. 9. The Legislative Committee shall give special attention to all legislation involving the interests of the Society.

SEC. 10. The Publishing Committee shall publish and issue the Transactions to all who are entitled to receive them within three months from the date of the meeting, unless otherwise directed by the Society at its annual meeting.

The Recording and Corresponding Secretaries and the Treasurer shall constitute this committee, but the number of members may be increased at the discretion of the Society.

ARTICLE VII.—PAPERS AND DISCUSSIONS.

SECTION 1. Each paper presented to the Society shall be through its appropriate bureau. All papers to be presented by any bureau shall be in the hands of the chairman thereof at the opening of the session; and it shall be the duty of each writer to prepare an abstract, which will accompany the paper when handed in, and the chairman shall decide whether the abstract only or the entire paper be presented to the meeting for its consideration and discussion. All papers shall be subject to the approval and revision of the Committee of Publication. No report or paper will be received by the Society in an incomplete or unfinished condition, and no paper shall be published as part of the Transactions which has been published previous to its presentation.

SEC. 2. Any paper may be published in a medical journal at any time subsequent to its presentation, provided that it be prepared in duplicate, and the original retained in the custody of the Committee on Publication.

SEC. 3. All communications read before the Society shall become its property; but no paper shall be published as part of the Transactions of the Society without its sanction.

SEC. 4. All discussions shall be strictly confined to the subject of the paper or report, and each speaker shall be limited to a speech of ten minutes, and to one of five minutes if he speaks a second time, and no excess of time shall be allowed except by consent of the Society. The reader of the paper shall be allowed ten minutes at the close of the discussion.

SEC. 5. Each county or local society shall be invited to prepare and discuss, during the year, a paper upon some medical subject,

and present it to the Society, at its annual meeting, through its appropriate bureau.

ARTICLE VIII.—Amendments.

These By-Laws may be altered or amended by a vote of two-thirds of the members present at any annual meeting.

ORDER OF BUSINESS.

1. Calling the meeting to order.
2. Address by the President.
3. Roll-call and correction of list of members.
4. Appointment of Committee on President's Address.
5. Report of Treasurer.
6. Appointment of Auditing Committee.
7. Report of Corresponding Secretary.
8. Reports of committees.
9. Report of Censors and election of members.
10. Reports of Bureaus.
11. Unfinished business.
12. New business.
13. Election of officers.
14. Announcement of bureaus and committees.
15. Adjournment.

LIST OF MEMBERS.

1885—Allen, John V., M.D., Frankford, Philadelphia.
1870—Allen, J. W., M.D., Altoona.
1883—Allen, Richard C., M.D., 4519 Frankford Ave., Phila.
1885—Arthur, Charles, M.D., Richfield, Kansas.
1889—Ashcraft, Leon, M.D., 2125 N. 17th Street, Philadelphia.
1889—Baily, H. W., M.D., Atlantic City, New Jersey.
1883—Baker, Alfred E., M.D., Norwynden Farm, West Chester.
1885—Baker, C. H., M.D., 34 N. 40th Street, Philadelphia.
1888—Baldwin, H. D., M.D., Montrose.
1881—Bartlett, Clarence, M.D., 1506 Girard Avenue, Phila.
1889—Bayley, Weston D., M.D., 1260 N. 6th Street, Philadelphia.
1885—Berkenstock, W. F., M.D., 1919 Girard Avenue, Phila.
1875—Betts, B. F., M.D., 1609 Girard Avenue, Philadelphia.
1886—Bier, P. A., M.D., 4200 Butler Street, Pittsburgh.
1872—Bigler, W. H., M.D., 118 N. 12th Street, Philadelphia.
1873—Bingaman, C. F., M.D., 922 Penn Avenue, Pittsburgh.
1886—Bonnet, Gustav E., M.D., 636 N. 11th Street, Philadelphia.
1872—Bowie, A. P., M.D., Uniontown.
1884—Boyd, G. S., M.D., Beaver Falls.
1880—Boyd, J. S., New Brighton.
1882—Boyer, Francis W., M.D., Pottsville.
1875—Bradford, L. J., M.D., Sylvania.
1883—Branson, Mary, M.D., 1719 Arch Street, Philadelphia.
1872—Brickley, Obadiah C., M.D., York.
1887—Briggs, E. E., M.D., 20 Washington Avenue, Pittsburgh.
1887—Briggs, H. G., M.D., 20 Washington Avenue, Pittsburgh.
1881—Brooks, Charles M., M.D., 1613 N. Tenth Street, Phila.
1883—Brown, Samuel, M.D., 651 N. 10th Street, Philadelphia.
1885—Buchman, Frank, M.D., 1410 S. 5th Street, Philadelphia.
1879—Buck, M. J., M.D., Altoona.
1886—Bulick, T. M., M.D., Altoona.

1877—Bullard, J. A., M.D., 130 S. Main Street, Wilkes-Barre.
1881—Bunting, H. M., M.D., Norristown.
1888—Burchfield, S. E., M.D., 803 Ligonier Street, Latrobe.
1866—Burgher, J. C., M.D., 960 Penn Avenue, Pittsburgh.
1889—Caley, Joseph M., M.D., Broad and Green Streets, Phila.
1868—Carmany, C. J., M.D., Harrisburg.
1888—Carmichael, T. H., M.D., 4467 Main Street, Germantown, Philadelphia.
1873—Chantler, I. B., M.D., Sewickley.
1875—Chapman, Millie J., M.D., 916 Penn Avenue, Pittsburgh.
1888—Chisolm, H. C., M.D., 407 Washington Street, Huntingdon.
1885—Christine, G. Maxwell, M.D., 2043 N. 12th Street, Phila.
1889—Clark, Anna C., M.D., Allentown.
1886—Closson, J. H., M.D., 21 W. Chelten Avenue, Germantown, Philadelphia.
1883—Coe, Sarah J., M.D., Wilkes-Barre.
1873—Cook, I. Elmer, M.D., Harrisburg.
1889—Coolidge, J. W., M.D., Scranton.
1889—Cooper, Isaac, M.D., Trenton, N. J.
1887—Cooper, John, M.D., 42 N. Diamond Street, Allegheny.
1866—Cooper, J. F., M.D., 105 Arch Street, Allegheny.
1887—Cowley, William, M.D., 6442 Penn Avenue, Pittsburgh.
1882—Cranch, Edward, M.D., 109 W. 9th Street, Erie.
1875—Crawford, J. S., M.D., Greensburg.
1883—Crowther, Isaac, M.D., Chester.
1883—Davis, E. Everett, M.D., 4321 Aspen Street, Philadelphia.
1882—Dean, E. W., M.D., Braddock.
1885—Deardorff, J. H., M.D., Mechanicsburg.
1866—Detwiller, John J., M.D., Easton.
1879—Detwiller, J. W., M.D., Bethlehem.
1886—Dietz, W. G., M.D., Hazelton.
1878—Dinsmore, S. W. S., M.D., Sharpsburg.
1880—Doolittle, E. D., M.D., Easton.
1867—Dudley, Pemberton, M.D., 15th and Master Streets, Phila.
1878—Duff, P. S., M.D., Great Belt.
1882—Du Four, W. M., M.D., 755 W. Third Street, Williamsport.
1889—Dumont, Anna E., M.D., 17th St., below Girard Ave., Phila.
1875—Dunn, James L., M.D., Titusville.

1881—Dunning, T. S., M.D., 1328 N. 15th Street, Philadelphia.
1870—Earhart, J. R., M.D., 1904 Arch Street, Philadelphia.
1873—Edmundson, W. F., M.D., 375 Fifth Avenue, Pittsburgh.
1882—Evans, H. J., M.D., Altoona.
1880—Ferson, J. L., M.D., 139 Wylie Avenue, Pittsburgh.
1889—Fickel, J. G., M.D., Carlisle.
1884—Fleming, R. K., M.D., 6217 Station Street, Pittsburgh.
1883—Fornias, Eduardo, M.D., 711 Pine Street, Philadelphia.
1889—Fryer, Nevins W., M.D., 402 S. Broad Street, Philadelphia.
1873—Fulton, H. W., M.D., 5949 Penn Avenue, Pittsburgh.
1889—Gangloff, Charles, M.D., 6 S. Main Street, Pittsburgh.
1867—Garvin, John J., M.D., 1546 N. 11th Street, Philadelphia.
1866—Gause, Owen B., M.D., Aiken, S. C.
1886—Gerhart, Joseph M., M.D., 603 N. 12th Street, Phila.
1870—Gessler, C. W., M.D., 1332 S. 5th Street, Philadelphia.
1879—Getze, G. M., M.D., Tarentum.
1885—Giles, J. William, M.D., 1930 Chestnut Street, Phila.
1875—Goodno, W. C., M.D., 4003 Chestnut Street, Philadelphia.
1875—Graham, D. M., M.D., Chicago, Ill.
1883—Gramm, E. M., M.D., 934 N. 6th Street, Philadelphia.
1867—Gramm, G. E., M.D., Ardmore.
1883—Gramm, Theo. J., M.D., 1409 Hanover Street, Philadelphia.
1889—Gregory, G. W., M.D., Troy.
1886—Griffith, J. J., M.D., Manayunk, Philadelphia.
1888—Griffith, Lewis B., M.D., 2514 Ridge Avenue, Philadelphia.
1881—Griffith, Silas, M.D., 1431 Girard Avenue, Philadelphia.
1877—Griffith, W. M., M.D., 2035 Ridge Avenue, Philadelphia.
1886—Grimes, Thomas H., M.D., Sewickley.
1888—Gross, F. O., M.D., 1808 N. 8th Street, Philadelphia.
1874—Guernsey, J. C., M.D., 1923 Chestnut Street, Philadelphia.
1867—Gumpert, B. Barton, M.D., 840 Franklin Street, Phila.
1886—Gundlach, F. C., M.D., 1722 Sarah Street, Pittsburgh.
1885—Haines, O. S., M.D., 137 N. 15th Street, Philadelphia.
1879—Hall, William D., M.D., Altoona.
1887—Haman, W. A., M.D., Reading.
1889—Hamer, J. H., M.D., 113 S. 16th St., Philadelphia.
1883—Hancock, Joseph, M.D., 1639 Columbia Avenue, Phila.
1888—Harner, John E., M.D., Honeybrook.

1884—Harris, D. R., M.D., 41 N. Jefferson Street, New Castle.
1883—Hassler, W. A., M.D., 105 N. Eighth Street, Allentown.
1881—Hawley, Annie M., M.D., Pughtown, Chester County.
1883—Helfrich, J. H., M.D., Allentown.
1873—Herron, C. D., M.D., 3505 Butler Street, Pittsburgh.
1882—Hofmann, C. H., M.D., 808 Penn Avenue, Pittsburgh.
1866—Hofmann, H. H., M.D., 808 Penn Avenue, Pittsburgh.
1883—Holben, M. J., M.D., Slatington.
1887—Holcombe, J. R., M.D., 1327 Girard Avenue, Philadelphia.
1889—Hoover, G. M., M.D., Mechanicsburg.
1883—Horner, J. Richey, M.D., 91 Arch Street, Allegheny.
1889—Hoy, H. K., M.D., Bellefonte.
1889—Hubbard, C. H., M.D., Millville, N. J.
1880—Humes, J. R., M.D., Hollidaysburg.
1886—Ingersoll, W. K., M.D., 4008 Chestnut Street, Phila.
1882—Ivins, Horace F., M.D., 1319 Arch Street, Philadelphia.
1883—Jackson, Lora C., M.D., 1526 Arch Street, Philadelphia.
1888—Jackson, W. H., M.D., Oil City.
1866—James, Bushrod W., M.D., 18th and Green Streets, Phila.
1885—James, Horace E., M.D., 1411 S. Broad Street, Phila.
1867—James, John E., M.D., 1521 Arch Street, Philadelphia.
1870—James, Walter M., M.D., 1123 Spruce Street, Phila.
1889—Jamison, M. R., M.D., Connellsville.
1888—Jennings, C. B., M.D., Reading.
1881—Johnson, Theodore M., M.D , 200 Susquehanna Ave., Pittston.
1869—Jones, Joseph E., M.D., 113 S. High Street, West Chester.
1881—Karsner, Daniel, M.D., 4830 Main Street, Germantown.
1889—Kase, Edmund H., M.D., 1323 Girard Ave., Philadelphia.
1885—Keim, William H., M.D., 2015 Ridge Avenue, Phila.
1875—Kern, W. H., M.D., McKeesport.
1884—King, W. D., M.D., 326 Fifth Avenue, Pittsburgh.
1887—Kistler, H. E., M.D., Johnstown.
1877—Knerr, C. B., M.D., N.E. cor. 12th and Spruce Sts., Phila.
1873—Koenig, M. J., M.D., Jersey Shore.
1872—Korndœrfer, Aug., M.D., 1728 Green Street, Phila.
1889—Lange, T. W., M.D., Scranton.
1888—Layman, Alfred, M. D., 1628 N. 18th Street, Phila.
1889—Lazear, Lyttleton Lyon, M.D., Pittsburgh.

1887—Leake, E. N., M.D., Butler.
1884—Lee, Charles H., M.D., New Castle.
1873—Lefever, Isaac, M.D., Harrisburg.
1866—Liscomb, P. D., M.D., Beaver Falls.
1868—Macfarlan, Malcolm, M.D., 1805 Chestnut Street, Phila.
1886—Maddux, D. P., M.D., Chester.
1883—Maguire, W. T., M.D., Darby.
1877—Malin, William H., M.D., Chestnut Hill, Philadelphia.
1881—Mansfield, J. R., M.D., 4852 Main Street, Germantown.
1886—Marks, W. F., M.D., Reading.
1885—Marsden, Biddle R., M.D., Chestnut Hill, Philadelphia.
1883—Marshall, Anna M., M. D., 1608 Mt. Vernon St., Phila.
1877—Martin, W. J., M.D., 1712 Carson St., S. S., Pittsburgh.
1878—Maurer, J. M., M.D., Washington.
1881—Mercer, Robert P., M.D., 223 W. Third Street, Chester.
1888—Mercer, E. W., M.D., 157 N. 15th Street, Philadelphia.
1888—Mercer, C. S., M.D., Media.
1888—Merriam, Franklin E., M.D., 2102 N. 11th Street, Phila.
1888—Messervè, F. W., M.D., 110 N. 15th Street, Phila.
1871—Middleton, Caleb S., M.D., 1523 Girard Avenue, Phila.
1887—Millen, J. C., M.D., 540 N. 12th Street, Philadelphia.
1877—Miller, Z. T., M.D., 2013 Carson Street, S. S., Pittsburgh.
1883—Mitchell, J. N., M.D., 1222 Walnut Street, Philadelphia.
1875—Mohr, Charles, M.D., 555 N. 16th Street, Philadelphia.
1867—Morgan, John C., M.D., 110 S. 17th Street, Philadelphia.
1889—Morrow, E. H., M.D., 1407 Eleventh Avenue, Altoona.
1881—Mullen, S. A., M.D., West Chester.
1883—Mullin, W. P., M.D., 5007 Green Street, Germantown.
1888—Murdock, Robert, M.D., Wilkes-Barre.
1879—McClelland, J. B., M.D., 411 Penn Avenue, Pittsburgh.
1867—McClelland, J. H., M.D., 411 Penn Avenue, Pittsburgh.
1884—McClelland, R. W., M.D., 411 Penn Avenue, Pittsburgh.
1883—McClure, Eliza H. Lang, M.D., 1919 Wallace St., Phila.
1888—McDowell, Charles H., M.D., 1031 Shackamaxon St., Phila.
1866—Neville, W. H. H., M.D., 19th and Wallace Streets, Phila.
1886—Oatley, E. L., M.D., 4003 Chestnut Street, Philadelphia.
1887—Page, Henry A., M.D., 6312 Penn Avenue, Pittsburgh.
1884—Parker, G. W., M.D., 1404 S. 6th Street, Philadelphia.

1883—Parker, T. Ellwood, M.D., Woodbury, N. J.
1870—Parsons, Anson, M.D., Springboro.
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1880—Peach, William, M.D., 76 Monterey Street, Allegheny City.
1885—Peacock, William, M.D., 2217 N. 6th Street, Philadelphia.
1881—Perkins, C. W., M.D., 403 Broad Street, Chester.
1883—Pettingill, Eliza F., M.D., 300 N. 10th Street, Phila.
1889—Phillips, Hibbard S., M.D., 326 Fifth Avenue, Pittsburgh.
1870—Pierce, W. A. D., M.D., 2004 Mt. Vernon Street, Phila.
1880—Pitcairn, Hugh, M.D., Harrisburg.
1886—Posey, L. P., M.D., 1132 Arch Street, Philadelphia.
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1866—Raue, Charles G., M.D., 121 N. 10th Street, Philadelphia.
1883—Reading, J. H., M.D., 1811 Green Street, Philadelphia.
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1873—Roseberry, C. I., M.D., Easton.
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1872—Rutter, J. C., M.D., Bloomsburg.
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1872—Sartain, Harriet J., M.D., 212 West Logan Square, Phila.
1874—Schmucker, F. R., M.D., Reading.
1883—Schreiner, Emma T., M.D., Germantown, Philadelphia.
1889—Schwenk, C. S., M.D., 1319 Jefferson Street, Philadelphia.
1880—Scott, S. C., M.D., Pittsburgh.
1886—Seibert, W. A., M.D., Easton.
1868—Seip, C. P., M.D., 636 Penn Avenue, Pittsburgh.
1889—Shallcross, I. G., M.D., 1631 Arch Street, Philadelphia.

1875—Shannon, O. R., M.D., 207 Lacock Street, Allegheny.
1879—Shannon, S. F., M.D., Denver, Col.
1883—Sharkey, W. P., M.D., 1938 Girard Avenue, Philadelphia.
1888—Sharpless, E. S., M.D., N.E cor. 11th and Ogden Sts., Phila.
1885—Shellenberger, C. N., M.D., 1831 Wallace Street, Phila.
1883—Shemp, P. D., M.D., Philadelphia.
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1883—Slough, F. J., M.D., 845 Hamilton Street, Allentown.
1883—Slough, W. C. J., M.D., Emaus.
1880—Smedley, I. G., M.D., 1705 Arch Street, Philadelphia.
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1889—Smith, T. Hart, M.D., 1309 Girard Avenue, Philadelphia.
1887—Snader, E. R., M.D., 140 N. 20th Street, Philadelphia.
1887—Speakman, W. W., M.D., 1921 Chestnut Street, Phila.
1870—Spencer, J. H., M.D., 1523 Girard Avenue, Philadelphia.
1889—Spencer, William, M.D., 1523 Girard Avenue, Philadelphia.
1889—Stafford, C. S., M.D., 2015 N. 19th Street, Philadelphia.
1881—Stambach, H. L., M.D., Santa Barbara, California.
1883—Starr, Samuel, M.D., 215 E. Fifth Street, Chester.
1889—Starr, Pearl, M.D., Bellevue.
1883—Stewart, H. Knox, M.D., 810 N. Broad Street, Philadelphia.
1883—Still, Horace, M.D., Norristown.
1885—Strong, J. Wilmer, M.D., 2049 N. 13th Street, Phila.
1889—Strong, Walter, M.D., Hahnemann Hospital, Philadelphia.
1889—Stubbs, G. P., M.D., Hahnemann Hospital, Philadelphia.
1888—Sullivan, J. Bailey, M.D., 210 Penn Avenue, Pittsburgh.
1881—Swartz, J. R., M.D., Harrisburg.
1889—Titman, George W., M.D., 5659 Germantown Ave., Phila.
1881—Thatcher, J. W., M.D., 35th and Hamilton Streets, Phila.
1871—Thomas, A. R., M.D., 113 S. 16th Street, Philadelphia.
1877—Thomas, Charles Monroe, M.D., 1623 Arch St., Phila.
1886—Tindall, Van R., M.D., 240 Federal Street, Philadelphia.
1886—Thompson, J. H., M.D., 960 Penn Avenue, Pittsburgh.
1887—Thompson, Landreth W., M.D., 1031 Green Street, Phila.
1884—Tomlinson, W. H., M.D., 5210 Main Street, Germantown.
1888—Tonkin, William, M.D., 938 N. 10th Street, Phila.

1881—Toothaker, C. E., M.D., Wylie Street, Philadelphia.
1881—Umstead, D. B., M.D., Tacony, 23d Ward, Phila.
1887—Uncapha, Elizabeth, M.D., Butler Street, Pittsburgh.
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1883—Van Baun, W. W., M.D., 419 Pine Street, Philadelphia.
1886—Van Deusen, Edwin, M.D., 2101 Tioga Street, Phila.
1883—Van Deusen, Josephine, M.D., 21st and Tioga Sts., Phila.
1881—Van Lennep, W. B., M.D., 1421 Spruce Street, Phila.
1889—Vischer, Carl V., M.D., 1421 Spruce Street, Philadelphia.
1867—Walker, Mahlon M., M.D., 12 W. Walnut Lane, Germantown, Philadelphia.
1881—Wareheim, Edward A., M.D., Glen Rock.
1870—Waters, George H., M.D., 474 N. 6th Street, Philadelphia.
1881—Weaver, Chandler, M.D., Fox Chase, 23d Ward, Phila.
1883—Weaver, W. P., M.D., Bristol.
1889—White, Elmer T., M.D.
1870—White, N., M.D., New Castle.
1889—White, R. T., M.D., 53 Jackson Street, Allegheny.
1887—Wilcox, F. P., M.D., Clifton Springs, New York.
1887—Wildman, Elias, M.D., Yardley.
1866—Willard, L. H., M.D., cor. Allegheny and Western Avenues, Allegheny City.
1881—Williams, H. E., M.D., Coatesville.
1866—Williams, Thomas C., M.D., 567 N. 5th Street, Phila.
1873—Williamson, M. S., M.D., 1311 Arch Street, Phila.
1870—Willets, William, M.D., Williamsport.
1886—Wilson, C. A., M.D., cor. Western and Allegheny Avenues, Allegheny City.
1877—Winslow, W. H., M.D., 956 Penn Avenue, Pittsburgh.
1887—Wolfe, W. W., M.D., 35 North Diamond Street, Allegheny.
1883—Wood, H. C., M.D., West Chester.
1883—Yearsley, William, M.D., 1532 N. 13th Street, Phila.
1888—Yocum, C. A., M.D., Pottstown.
1880—Yoder, D., M.D., Catasauqua.
1874—Young, J. H., M.D., 1630 Green Street, Philadelphia.

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1883—Allen, H. C., M.D., Ann Arbor, Mich.
1868—Dake, Jabez P., M.D., Nashville, Tenn.
1866—Doran, Charles R., M.D., Jacksonville, Fla.
1886—Dowling, John W., M.D., 6 E. 43d Street, New York City.
1868—Helmuth, William Tod, M.D., 158 W. 59th Street, New York.
1885—Houghton, Henry C., M.D., 12 W. 39th Street, New York City.
1876—Jones, S. A., M.D., Ann Arbor, Mich.
1876—Lilienthal, S., M.D., 1316 Van Ness Street, San Francisco, Cal.
1868—Paine, H. M., M.D., 106 State Street, Albany, N. Y.
1883—Phillips, W. A., M.D., Cleveland, Ohio.
1868—Rockwith, F. A., M.D., East Saginaw, Mich.
1868—Talbot, I. T., M.D., 66 Marlborough Street, Boston, Mass.

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1873—Alvarez, Paz, M.D., Madrid, Spain.
1873—Chauvet, Fernand, M.D., Tours, France.
1873—Eidherr, Francis, M.D., Vienna, Austria.
1883—Hughes, Richard, M.D., Brighton, England.
1873—Pope, Alfred C., M.D., London, England.

NECROLOGICAL LIST.

1866—Ashton, A. H., M.D., died February 18th, 1883.
1866—Barnaby, John E., M.D., died January 5th, 1869.
1867—Barrett, Charles B., M.D., died June 5th, 1871.
1882—Bernard, H., M.D., died ————
1866—Blakely, W. James, M.D., died January 14th, 1877.
1870—Bratt, Benjamin R., M.D., died January 31st, 1872.
1866—Brooks, Silas S., M.D., died July 2d, 1871.
1883—Burr, Richard, M.D., died March 30th, 1885.
1873—Caruthers, R. E., M.D., died January 3d, 1885.
1868—Charlton, S. T., M.D., died November 9th, 1886.
1863—Childs, William R., M.D., died November 11th, 1888.
1866—Cooke, William H., M.D., died March 11st, 1879.
1866—Cote, M., M.D., died May 29th, 1878.
1866—Cowley, David, M.D., died October 30th, 1886.
1866—Detweiler, Henry, M.D., died April 21st, 1887.
1871—Dreibelbis, David L., M.D., died March 24th, 1872.
1870—Farrington, E. A., M.D., died December 17th, 1885.
1866—Friese, Michael, M.D., died February 4th, 1880.
1866—Frost, J. H. P., M.D., died January 21st, 1875.
1866—Gardiner, Richard, M.D., died March 22d, 1877.
1883—Gause, Percival O. B., M.D., died November 10th, 1887.
1877—Grumbein, William, M.D., died ————
1866—Guernsey, H. N., M.D, died June 27th, 1885.
1870—Guernsey, W. F., M.D., died February 16th, 1877.
1888—Hawley, S. B., M.D., died March 6th, 1890.
1886—Herron, James A., M.D., died November 15th, 1868.
1884—Hosfeld, George, M.D., died November 9th, 1884.
1873—Houard, J. G., M.D., died April 24th, 1878.
1866—James, David, M.D., died June 6th, 1873.
1886—Jeanes, Jacob, M.D., died December 18th, 1877.

1866—Koch, Augustus W., M.D., died May 4th, 1886.
1866—Lee, J. K., M.D., died November 10th, 1887.
1869—Lee John K., M.D., died May 31st., 1889.
1867—Lippe, Adolph, M.D., died January 23d, 1888.
1871—Lovejoy, E., M.D. (honorary), died August 15th, 1872.
1868—Malin, George W., M.D., died January 18th, 1883.
1886—Malin, John, M.D., died November 29th, 1889.
1866—Marsden, J. H., M.D., died August 27th, 1883.
1865—Martin, Henry Noah, M.D., died September 1st, 1889.
1839—May, Newton, M.D., died January 27th, 1889.
1866—McClatchey, R. J., M.D., died January 15th, 1883.
1870—Moore, Thomas, M.D., died March 25th, 1882.
1873—Nichol, Thomas, M.D. (corresponding), died June, 14th, 1890.
1869—Ostrander, W. M., M.D., died August 23d, 1881.
1868—Payne, Wm. E., M.D. (honorary), died March 9th, 1877.
1878—Pereira, Ignacio, M.D. (corresponding), died April 18th, 1881.
1868—Pfoutz, J. S., M.D., died ————
1866—Preston, Coates, M.D., died August 9th, 1881.
1868—Pulte, J. H., M.D. (honorary), died February 24th, 1884.
1882—Pursel, J. E., M.D., died March 15th, 1885.
1853—Reading, Edward, M.D., died March 7th, 1889.
1866—Reading, John R., M.D.. died February 14th, 1886.
1870—Reinhold, H. E., M.D., died March 6th, 1879.
1866—Roberts, R. Ross, M.D., died April 4th, 1875.
1866—Rosseau, L. M., M.D., died September 25th, 1882.
1872—Scott, James L., M.D., died August 15th, 1876.
1872—Speth, W. F., M.D., died May 11th, 1881.
————Stauffer, D. R., M.D., died March 16th, 1874.
1867—Stevens, C. A., M.D., died January 17th, 1881.
1870—Taudte, F., M.D., died March 27th, 1878.
1882—Trites, W. B., M.D., died January 19th, 1890.
1880—Way, J. H., M.D., died September 3d, 1887.
1866—Williamson, Walter M., M.D., died December 19th, 1870.
1866—Williamson, Walter, M.D., died May 5th, 1874.
1868—Wood, James B., M.D., died April 14th, 1889.
1880—Zerns, William M., M.D., died September 21st, 1887.

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